Central Naugatuck Valley Regional Action Council

Epidemiologic Profile of Substance Use, Suicide & Problem Gambling

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Contributors

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Abbreviations

A & B..... Search Institute's Attitudes & Behaviors Survey: A Profile of Student Life
CDC ..... Centers for Disease Control
CNAW ..... Community Needs Assessment Workgroup
CNVRAC ..... Central Naugatuck Valley Regional Action Council
CSHS ..... Connecticut School Health Survey
CT..... Connecticut
DMHAS ..... Department of Mental Health & Addiction Services
DPH..... Department of Public Health
DOT..... Department of Transportation
DOJ ..... Department of Justice
LPC..... Local Substance Abuse Prevention Council
MTF ..... Monitoring the Future survey
NSDUH..... National Survey on Drug Use and Health
OTC ..... Over-the-counter
PGS ..... Problem Gambling Services
RAC..... Regional Action Council
SDE ..... State Department of Education
SEOW..... Statewide Epidemiological Outcomes Workgroup
YRBS..... Youth Risk Behavior Survey

Executive Summary

This profile contains information which helps the CNVRAC to accurately describe the demographics and key substance abuse priorities in sub-region 5 B of Connecticut. Data is used to identify levels of consumption and the consequences arising from substance use, misuse, abuse and addictions across our 12 towns. We focus our attention specifically on eight issues: alcohol, tobacco, marijuana, prescription drugs, heroin, cocaine, problem gambling and suicide. Throughout the document there are references to associated behaviors, such as violence and depression, which are important, but for purposes of this report we restrict our individual "profiles" to these eight.

The priority setting process was first conducted by CNVRAC in 2006 and we have followed a similar course every two years since. The key participants from our communities have become familiar with this process, which has been a benefit to the overall development of the report.

In the end, our priority ranking matrix looked much the same as it did two years ago. Alcohol/Underage Drinking remains the number one priority (13.5) with marijuana use (11) and prescription drug misuse (10.5), coming in second and third, respectively. In addition to the priority substances addressed by this process, Community Needs Assessment Workgroup members identified a suggestion for subsequent profiles, which is to address "emerging trends" with a commentary on the most recent "hot topic" substances and risks of concern that are occurring in the community. Most notably, synthetic cannabinoids (Spice, herbal incense), mephedrone (bath salts), and pure MDMA (Molly), are the new substances being identified most in emergency department visits and school counseling offices. Anecdotal data on these or similar substances of concern should be addressed in future epi-profiles as trends emerge and become an issue.

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Introduction

Background, History, and Purpose of the Profile

Since 2004, DMHAS has practiced SAMHSA'S Strategic Prevention Framework (SPF) at the State, subregional, and community levels. The SPF is a five-step, data-driven process known to promote youth development and prevent problem behaviors across the life span. The steps are 1) profile needs and response capacity; 2) mobilize and build needed capacity; 3) develop a strategic prevention plan; 4) implement evidence-based programs and strategies; and 5) monitor and evaluate effectiveness.

Connecticut is fortunate to have legislatively created geographic planning councils - Regional Action Councils (RACs) - who are ideally positioned to profile needs and response capacity in the communities they serve. Their mandate is to "(1) determine the extent of the substance abuse problems within their subregions; (2) determine the status of resources to address such problems; (3) identify gaps in the substance abuse service continuum; (4) identify changes to the community environment that will reduce substance abuse…"[1] Furthermore, the legislation requires that they comprise their membership of diverse members of the community, including, chief elected official, the chief of police and the superintendent of schools of each municipality within the subregion, one representative designated by the Commissioner of Mental Health and Addiction Services from each health promotion facility operated by the department and serving such subregion, business and professional leaders, members of the General Assembly, service providers and representatives of minority populations, religious organizations, representatives of private funding organizations and the media. These mandates fit seamlessly with the first step of the SPF.

Using data provided by CT's State Epidemiologic Outcomes Workgroup as well as data collected locally, each RAC produces a Subregional Epidemiologic Profile for the following statewide priorities:

- Alcohol use and its consequences
- Tobacco use and its consequences
- Prescription drug use and its consequences
- Marijuana use and its consequences
- Heroin use and its consequences
- Cocaine use and its consequences
- Problem gambling and its consequences
- Suicide and its consequences

To assist in the development of the profile and to prioritize needs, each RAC convenes a Community Needs Assessment Workgroup (CNAW) who represent, or have interests in, the sub-region. Typically, the CNAW includes members of the Prevention and Treatment Committees and other key stakeholders.

The profile is used as a building block for state and community-level processes, including capacity and readiness building, strategic planning, identification of appropriate, evidence-based programs and strategies, and evaluation of efforts to reduce substance abuse and promote mental health. RACs publicize the information based on the profiles, engage other organizations (especially schools) in gathering and sharing data, and inform the community via newsletters, social marketing, etc.

[1] Connecticut Statute Sec. 17a-671

Data Sources, Strengths, and Limitations

Data for this profile was gathered from local, state, and national-level sources. Where available, data from sources such as NSDUH, the CDC, and the MTF study are included for an "across the nation" look at substance use and other behavior & activities, consequences, and emerging trends. The Statewide Epidemiological Outcomes Workgroup (SEOW) includes much of this data in CT's Behavioral Health Indicator Portal, as well as state, and town by town level information where available. Much of the state, regional, and sub-regional data sources that are available come from agencies such as DMHAS, DPH, DOT, DOJ, SDE, and other state-level data collection sources. Locally, unless youth and community surveys are administered, town by town data can be a challenge to collect, especially if it has not resulted in some kind of consequence of which that data is collected by another source, such as a Driving Under the Influence of Alcohol arrests, a school suspension/expulsion for possession, sale or distribution of an illegal substance, or an intervention, treatment, or overdose resulting in death episode, that may be recorded by another state agency, medical department, or state/federal source.

For the purpose of this report, much local-level youth risk-taking activity including substance use, thoughts of suicide, and gambling activity, has been gathered using the Search Institute's Attitudes & Behaviors Survey: A Profile of Student Life. The A&B survey has been administered by school districts in collaboration with the CNVRAC and each community's Local Substance Abuse Prevention Council, or LPC for the purpose of getting a first time, first-hand look at the attitudes and behaviors of young people in a community that may not see a high magnitude of consequences related to risk-taking activity, but that hears anecdotally that problems exist. Having current, local-level data is an excellent way to dispel the myths of "that's not a problem here, it happens in that town over there" or the "everybody's doing it" perception that some groups may have.

Research: At the Core of Search Institute

For 50 years, Search Institute has conducted multiple types of research in an effort to understand young people, their communities, and the people who influence them. This research includes ground-breaking studies on child and adolescent development, family life, and community and social change.

Just as important as the quality of the research is their commitment to making the research actionable. They seek to reframe challenges and issues to emphasize breakthrough strategies for making a positive difference in the lives of young people and the people who shape their lives.

The CNVRAC has worked with communities in its sub-region that have never collected local-level youth data and we work with those communities to understand what their data means to them, and how to begin taking action based on their survey results.

Profile Strengths & Limitations (See also APPENDIX 1)

To date, seven of CNVRAC's nine school districts have used this survey instrument to conduct local-level needs assessment. A "snapshot" of the results across our service area has been included in each profile. Users should exercise caution with interpretation of this data. It has been gathered by different school districts with different population samples from 2009 – 2012. The total sample includes youth from grades 6 – 12, but not all school districts surveyed all grades or all youth in a particular grade. The majority of survey groups included all youth in grades 7-12. One school district surveyed only 8th and 10th grade youth. Another district surveyed only a sample of youth in grades 6, 9, and 12.

In addition, when similar information is available, the CT School Health Survey results are also included in profiles. It is the intention of this report to give the reader a local-level "snapshot" of substance use, other risk-taking behavior, and related information; a sample of statewide behavior and activity where available; and a national-level look at this particular area as it occurs across the United States. The purpose of this is to allow a focused look at the issue as well as to deliver a wide-angle perspective in order to give the reader a context for the information presented herein.

Profile Development (See also APPENDIX 2)

It is the role of the CNVRAC to conduct ongoing needs assessment in order to support community planning and to provide leadership on these issues. In addition to completing the biannual profiles, CNVRAC works constantly to develop and maintain a bank of current data and to find additional sources of data that support anecdotal accounts of current or changing levels of magnitude and impact on communities. In addition, we strive to develop and maintain relationships

with key stakeholders that are invested in the process of creating health & wellness for their residents. These naturally occurring groups are called upon during profile development to contribute their perceptions, understanding, and suggestions for change to these profiles as the data becomes available. Either as groups and/or individually, committees and members of the CNVRAC community complete the priority ranking matrix, make inquiries about areas CNVRAC can provide additional data on, and deliver recommendations for strategies to affect the priority and other areas of this profile. Recommendations typically include continued monitoring and data collection, awareness raising, education and advocacy, creation and enforcement of laws and policies, connecting those at-risk and in-need to appropriate services within the community, and garnering of funding to close gaps in service delivery.

Description of the RAC region

The Central Naugatuck Valley Regional Action Council, RAC sub-region 5-B of Northwestern CT, consists of the following 12 towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Thomaston, Waterbury, Watertown, Wolcott, and Woodbury.

Population ranges in the CNVRAC service area from small rural farming and agricultural communities such as the Town of Bethlehem, 3607 residents, to mid-size suburban manufacturing and industry areas such as the Borough of Naugatuck, population 31, 862 residents, to a large urban multicultural center, the City of Waterbury, home to 110,366 residents, all according to 2010 Census data. (See Figure 1)

Figure 1 – Population of CNVRAC service area

Area	Total Population 2010, Number	Total Population 2010, %	Age 0 to 4, %	Age 5 to 9, %	Age 10 to 17, %	Age 10 to 20, %	Age 18 to 24, %	Age 21 & Older, %	Age 25 to 59, %	Age 60 to 64, %	Age 65 to 74, %	Age 75 to 84, %	Age 85 & Older, %
Connecticut	3,574,097	100.0	5.7	6.2	13.7	17.9	9.2	70.2	48.1	5.7	7.1	4.7	2.4
Northwest	536,303	15.0	5.5	6.4	14.2	17.7	7.8	70.3	48.5	5.8	7.2	4.6	2.3
CNVRAC	**275,085**	**7.7**	**5.7**	**6.4**	**14.3**	**18.2**	**8.5**	**69.8**	**47.6**	**5.7**	**7.2**	**4.8**	**2.6**
Beacon Falls	6,049	0.2	5.3	6.3	13.2	16.8	6.9	71.5	50.7	6.5	8.1	3.3	1.5
Bethlehem	3,607	0.1	3.7	4.9	14.5	17.5	6.2	73.9	48.9	8.7	8.5	4.7	1.7
Cheshire	29,261	0.8	4.4	6.5	16.2	21.0	8.3	68.1	47.6	6.3	6.7	4.6	2.8
Middlebury	7,575	0.2	4.7	7.4	14.4	16.5	4.9	71.4	45.9	6.6	9.0	5.5	2.8
Naugatuck	31,862	0.9	5.9	6.1	13.5	17.4	8.8	70.6	50.9	5.4	6.3	3.6	2.0
Prospect	9,405	0.3	4.5	6.4	13.8	17.7	8.4	71.3	48.4	6.3	8.4	4.9	1.9
Southbury	19,904	0.6	3.6	5.7	12.6	15.2	4.8	75.5	41.3	7.2	10.2	9.9	6.2
Thomaston	7,887	0.2	4.6	6.3	14.2	17.5	7.3	71.6	51.0	6.0	7.0	4.2	2.1
Waterbury	110,366	3.1	7.2	6.8	14.7	18.6	10.0	67.5	47.0	4.7	6.1	4.2	2.4
Watertown	22,514	0.6	4.7	5.6	13.5	17.6	7.7	72.2	48.5	6.7	8.3	5.4	2.5
Wolcott	16,680	0.5	4.4	6.4	15.2	19.7	8.6	69.5	48.1	5.4	8.1	4.7	2.4
Woodbury	9,975	0.3	4.0	5.7	13.0	15.7	5.7	74.7	48.2	8.1	9.8	5.1	2.2

Source: 2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Southbury is special with regard to population in that is home to Heritage Village, a unique, 55+ active retirement community. As a result, more than 30% of Southbury's residents are over age 60, and that segment of the population is increasing.

The majority of communities across the CNVRAC sub-region are not ethnically diverse. According to 2010 census data, this sub-region is 71.4% White/non-Hispanic, 8.6% Black, 3.8% Asian, and 13.4% Hispanic or Latino ethnicity. Waterbury is an especially unique community, in that it is currently home to one of the largest Latino populations in the state. During the 2010 – 2011 school year, 45.2 percent of the district student population was white Hispanic. Waterbury overall has the greatest ethnic diversity of all CNVRAC communities, and Naugatuck is second, with an overall population that is 9.2% Hispanic and 4.5% Black & African American non-Hispanic. Cheshire has the largest Asian population of the service area at 5% of their residents. (see Figure 2)

Figure 2 – Ethnicity of the CNVRAC Service Area												
Area	Male, Percent	Female, Percent	Male Median Age	Female Median Age	Hispanic, Percent	White, Non-Hispanic, Percent	Black and African American, Non-Hispanic, Percent	American Native, Non-Hispanic, Percent	Asian, Non-Hispanic, Percent	Native Pacific Islander, Non-Hispanic, Percent	Other, Non-Hispanic, Percent	Multi-racial, Non-Hispanic, Percent
Connecticut	48.7	51.3	38.5	41.3	13.4	71.2	9.4	0.2	3.8	0.0	0.3	1.7
Northwest	48.8	51.2	44.1	46.1	13.1	75.7	5.7	0.2	3.0	0.0	0.7	1.6
CNVRAC	48.4	51.6	44.5	44.3	15.3	71.4	8.6	0.2	2.2	0.0	0.6	1.7
Beacon Falls	49.9	50.1	42.2	42.2	5.0	91.2	1.4	0.0	1.2	0.0	0.1	1.1
Bethlehem	49.3	50.7	43.4	47.8	1.7	96.4	0.4	0.1	0.5	0.0	0.1	0.8
Cheshire	51.9	48.1	36.8	44.7	4.7	84.2	4.7	0.1	5.0	0.0	0.1	1.2
Middlebury	48.4	51.6	45.6	44.7	2.7	91.4	0.9	0.1	3.8	0.0	0.2	0.9
Naugatuck	49.0	51.0	45.8	39.4	9.2	80.9	4.5	0.2	3.0	0.0	0.6	1.7
Prospect	48.2	51.8	43.4	44.5	3.3	92.9	1.9	0.1	0.8	0.0	0.1	0.9
Southbury	46.7	53.3	45.1	51.8	2.6	92.8	0.8	0.1	2.7	0.0	0.1	0.9
Thomaston	48.4	51.5	51.2	43	2.6	95.2	0.3	0.2	0.7	0.0	0.1	0.8
Waterbury	47.6	52.4	43	36.5	31.2	45.4	17.8	0.3	1.8	0.0	1.1	2.4
Watertown	48.5	51.5	46.9	45.2	3.7	92.0	1.3	0.2	1.7	0.0	0.1	1.0
Wolcott	48.4	51.6	47.9	43.5	3.7	92.1	1.6	0.1	1.2	0.0	0.2	1.1
Woodbury	48.5	51.5	42.4	47.7	2.5	93.9	0.6	0.2	1.7	0.0	0.1	1.1
Source: 2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.												

Also according to 2010 census data, across the sub-region, median household income is significantly higher than state level, and more than double that of the entire Northwestern part of the state, at $54,395. CNVRAC has a higher high school graduation and equivalency percent than state and the Northwestern region, but a lower percent of graduation or higher degree than the Northwest and state, and a lower professional degree attainment than the Northwest Region.

In addition to Waterbury maintaining the major ethnic diversity of the service area, it is also unique to the sub-region in its economic structure and availability of social service resources. Across all communities of the service area, 20.9% of Waterbury's population lives below the Poverty Level. This is more than double the poverty level of CT, the Northwestern Region and sub-region, and between 2 and 10 times the percent of neighboring communities. Waterbury residents are the least likely to obtain a high school diploma, Bachelor's degree (10.8%), or higher (16.9%). The average median earnings in the past 12 months for a Waterbury residents 25 years and older is $33, 048.

The community with the highest median household income (earning $59,447 in the past 12 months) and 51% of residents attaining a Bachelor's degree or higher is Cheshire. Thomaston has the lowest percent of residents living below Poverty Level at 1.8%, and all communities except for Waterbury have a Poverty Level lower than 10%.

Figure 3 – CNVRAC Service Area Socioeconomic Status: Poverty Level, Median Earnings, and Educational Attainment								
Area	Below Poverty Level, Percent	Median Earnings, Past 12 Months Dollars	High school graduate Percent	Some college, no degree, Percent	Bachelor's degree, Percent	Graduate or professional degree, Percent	High school graduate or higher, Percent	Bachelor's degree or higher, Percent
Connecticut	9.2	$43,324	28.6	17.3	19.9	15.3	88.4	35.2
Northwest	8.0	$24,549	28.94	16.84	20.83	20.83	88.53	88.53
CNVRAC	10.8	$54,395	32.26	17.63	16.93	16.93	86.32	86.32
Beacon Falls	3.8	$42,220	36.3	20.6	17.2	35.3	94	26.6
Bethlehem	2.0	$44,227	24.8	21.5	20.7	35.3	95.9	37.4
Cheshire	2.4	$59,447	20.7	15.7	27	35.3	94.3	51
Middlebury	2.0	$51,361	19.4	20.1	26.9	35.3	95.2	47.1
Naugatuck	7.5	$40,603	37.2	20.3	14.1	35.3	87.5	21.7
Prospect	2.4	$47,593	33.6	16.8	19.2	35.3	91.5	32.2
Southbury	5.9	$51,474	23.4	16.5	25.5	35.3	89.4	43.6
Thomaston	1.3	$43,152	35.8	19.1	19.3	35.3	91.7	25.6
Waterbury	20.9	$33,048	36.1	17	10.8	35.3	78.5	16.9
Watertown	3.1	$45,247	30.9	17.5	21.2	35.3	91	33.5
Wolcott	2.6	$45,409	37.6	21.1	15.1	35.3	92.1	23.8
Woodbury	5.6	$54,382	25.6	12.9	27.5	35.3	95.2	48.5
Source: 2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.								

Waterbury is further unique to the service area in that it is the metropolitan hub of the CNVRAC sub-region. Both hospitals in the service area are located in Waterbury. Four college campuses are found in Waterbury: Naugatuck Valley Community College, Post University, UCONN Waterbury Branch Campus, and the University of Bridgeport's Waterbury Center. A State Technical High School and multiple Magnet Schools that accept students from across CNVRAC and other service areas, can be found in Waterbury. Major substance abuse and mental health treatment providers are located here, as well as bus and train terminals to other parts of the state and beyond. Department of Public Health, Social Services, Court Services, Children & Families, and Social Security Administration offices are all located in and around downtown Waterbury.

Summary

Priority Ranking

CNAW Priority Ranking Matrix - Aggregate Scores				
SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest				
PROBLEM	**MAGNITUDE**	**IMPACT**	**CHANGEABILITY**	**TOTAL**
Alcohol	5	5	3.5	13.5
Tobacco	2	4	3	9
Marijuana	5	3	3	11
Prescription Drug Misuse	4	3.5	3	10.5
Heroin	2	4	2	8
Cocaine	2	3.5	2	7.5
Problem Gambling	1	2	2	5
Suicide	2	5	3	10

Prevention Priority 1: Alcohol

Magnitude

According to the World Health Organization's (WHO) Global Status Report on Alcohol and Health (2011), alcohol causes nearly 4 percent of deaths worldwide, more than AIDS, tuberculosis or violence. Rising incomes have triggered more drinking in heavily populated countries, and binge drinking is a problem in many developed countries, the United Nations agency said. Yet alcohol control policies are weak and remain a low priority for most governments despite drinking's heavy toll on society from road accidents, violence, disease, child neglect and job absenteeism, it said. Worldwide, approximately 2.5 million people die each year from alcohol related causes, according to the WHO. "Worldwide, about 11 percent of drinkers have weekly heavy episodic drinking occasions, with men outnumbering women by four to one. Men consistently engage in hazardous drinking at much higher levels than women in all regions," the report said.

Here in the U.S. alcohol is the most commonly used substance nationally and statewide. According to the 2010-2011 National Household Survey of Drug Use and Health (NSDUH), 59% of people age 12 or older in Connecticut were current users of alcohol. According to this same survey, young adults aged 18-25 in Connecticut had the highest rate of past-month alcohol use (69%), as well as the highest prevalence of binge drinking (49%) and alcohol abuse and dependence (19%). Data from the 2010 CORE Alcohol & Drug Survey indicates that: 82.2% of students consumed alcohol in the past year (annual prevalence0, 69.2% consumed alcohol in the past 30 days (30-day prevalence) 61.2% of underage students (younger than 21) consumed alcohol in the past 30 days, and 43.9% of students reported having binge drank within the past two weeks. Twenty-nine percent of students said that they had driven a car while under the influence of alcohol or other substance, 32% reported missing class, and 36% reported getting into a fight or an argument.

This survey, conducted on college campuses across the U.S. further identifies student opinion about campus policy and perceptions of use, alcohol's role in socialization, and real and perceived consequences of use and other attributable risk taking behavior. We know from previous priority setting processes that most adults begin using alcohol in adolescence, and underage drinking remains a significant problem both in the US and in Connecticut.

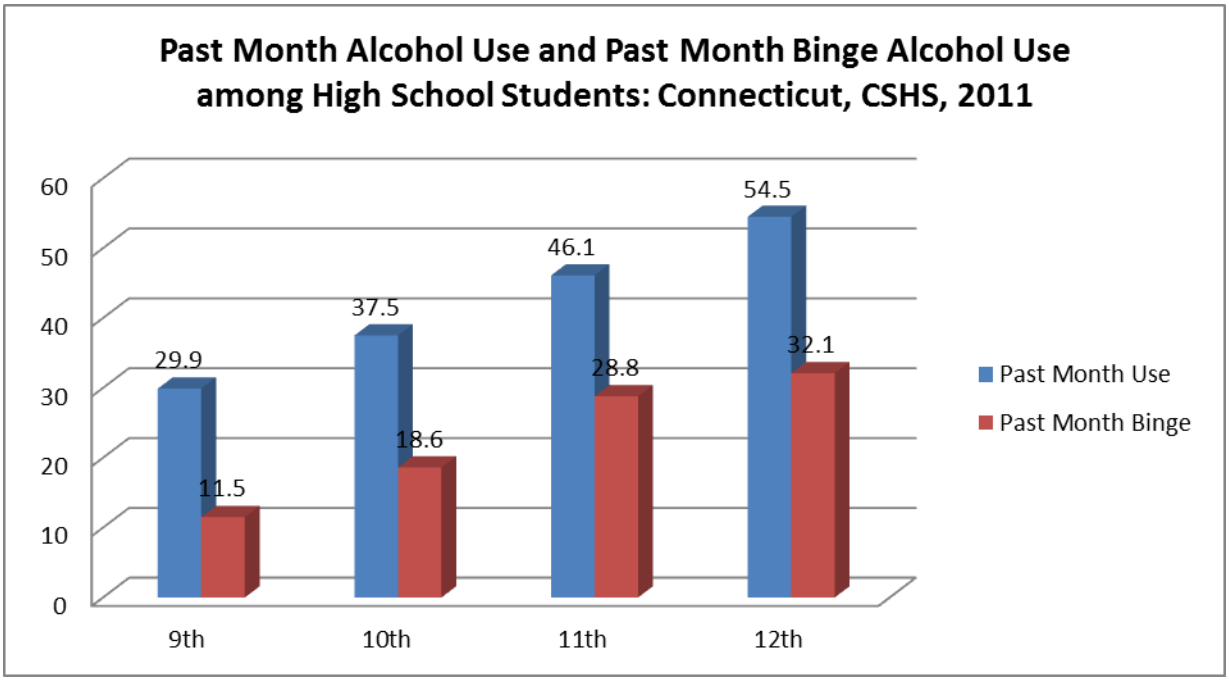
According to our 2009-2010 NSDUH data on alcohol use in the past month, CT has higher rates of use than the total U.S. and Northeastern U.S. CT's higher past 30 day use is consistent across all age groups as well. For 18 – 25 year olds though, which is always the group that has the highest past 30 day use of all age groups, the Northwestern region of CT, where the CNVRAC is located, has the lowest estimate of use, for all regions of CT.

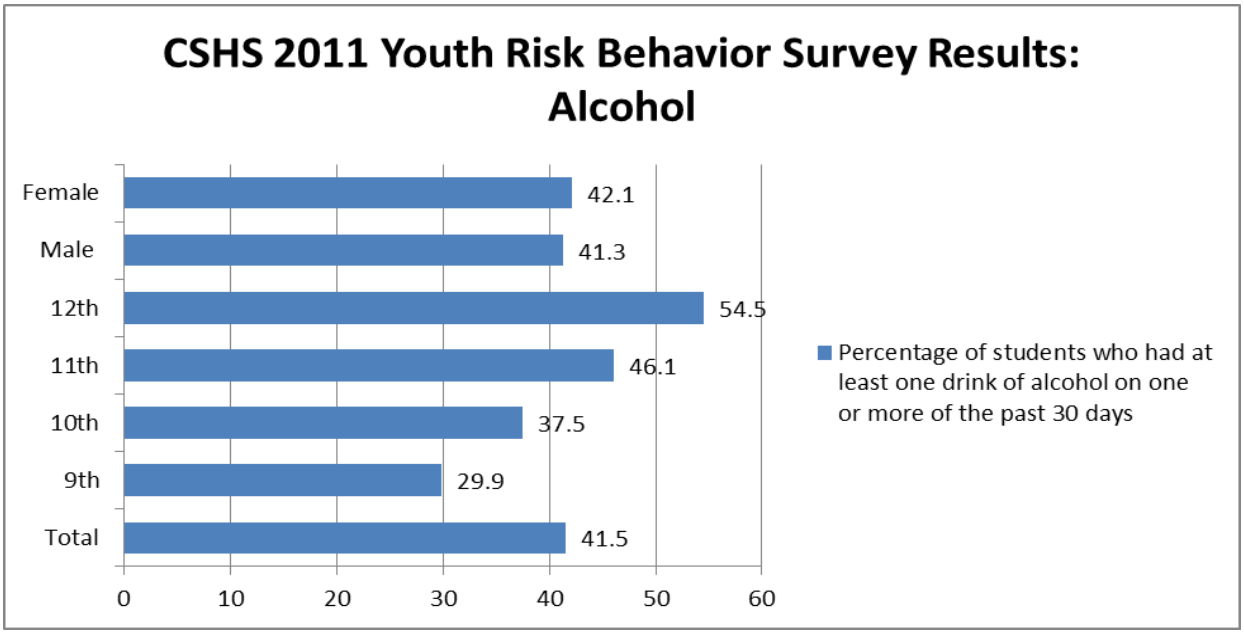
Alcohol Use in the Past Month, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

State/Substate Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	14.41	(14.03 - 14.81)	61.22	(60.60 - 61.84)	54.72	(54.14 - 55.30)	55.68	(55.17 - 56.19)
Northeast U.S.	16.36	(15.63 - 17.11)	67.07	(65.69 - 68.42)	59.76	(58.53 - 60.98)	60.81	(59.67 - 61.94)
Connecticut	18.18	(15.94 - 20.66)	68.22	(64.89 - 71.37)	63.29	(59.97 - 66.49)	63.98	(60.98 - 66.87)
Eastern	15.65	(11.85 - 20.38)	*	(* - *)	*	(* - *)	60.48	(54.11 - 66.52)
North Central	17.51	(14.30 - 21.26)	68.75	(63.31 - 73.73)	62.79	(57.72 - 67.59)	63.59	(58.98 - 67.97)
Northwestern	18.13	(14.26 - 22.76)	66.12	(59.43 - 72.22)	64.20	(58.50 - 69.52)	64.45	(59.18 - 69.39)
South Central	20.27	(16.24 - 25.01)	70.52	(64.98 - 75.50)	64.50	(58.99 - 69.65)	65.34	(60.40 - 69.97)
Southwest	18.27	(14.29 - 23.07)	*	(* - *)	64.31	(58.27 - 69.92)	64.69	(59.13 - 69.88)

* Low precision; no estimate reported.

Among CT youth in grades 9-12 (high school), 41.5% reported using alcohol in the past 30 days, and 21% reported binge drinking (CSHS Report, 2011).





Impact

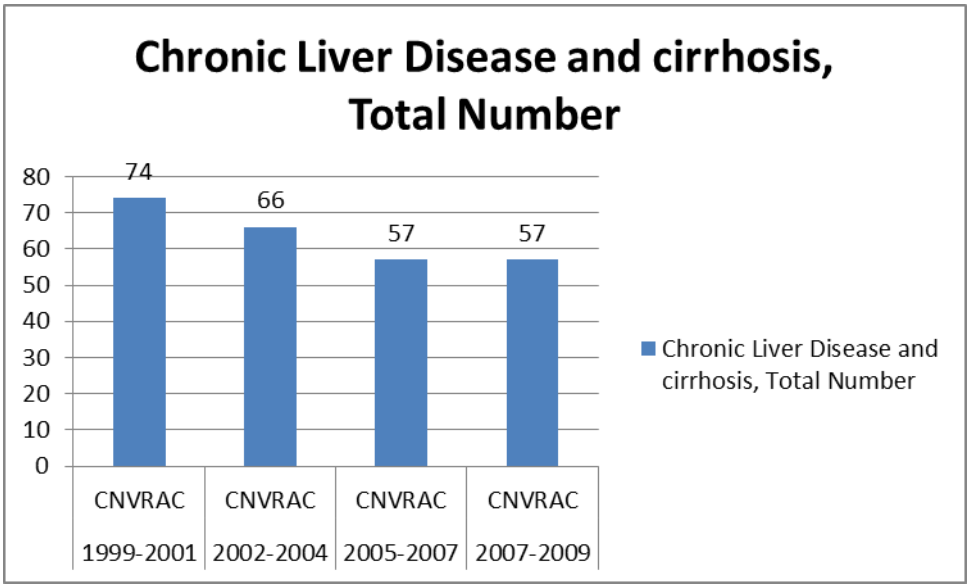
Alcohol is a causal factor in 60 types of diseases and injuries, (WHO, 2011). Its consumption has been linked to cirrhosis of the liver, epilepsy, poisonings, road traffic accidents, violence, and several types of cancer, including cancers of the colorectum, breast, larynx and liver. "The harmful use of alcohol is especially fatal for younger age groups and alcohol is the world's leading risk factor for death among males aged 15-59," the 2011 WHO report found. According to the Centers for Disease Control, 36 people die every day due to drunk drivers. The national annual cost of alcohol-related crashes totals more than $51 billion.

We know from past priority setting processes, our statewide prevention partners, and associated research that:

- Approximately 100,000 deaths each year in the U.S. are attributed to alcohol misuse.
- In Connecticut, underage drinking cost the state an estimated $0.6 billion in 2010... INSERT UNDERAGE DRINKING IN CT THE FACTS from GPP, here.

- Binge drinking, as indicated by consumption of five drinks or more within a short time span, is strongly associated with injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease and several other chronic and acute conditions.

- Studies have shown that long-term alcohol abuse produces serious, harmful effects on a variety of the body's organ systems, especially the liver and the immune, cardiovascular and skeletal systems.



- Immediate adverse effects of alcohol can include: impaired judgment, reduced reaction time, slurred speech, and unsteady gait. When consumed rapidly and in large amounts, alcohol can also result in coma and death.

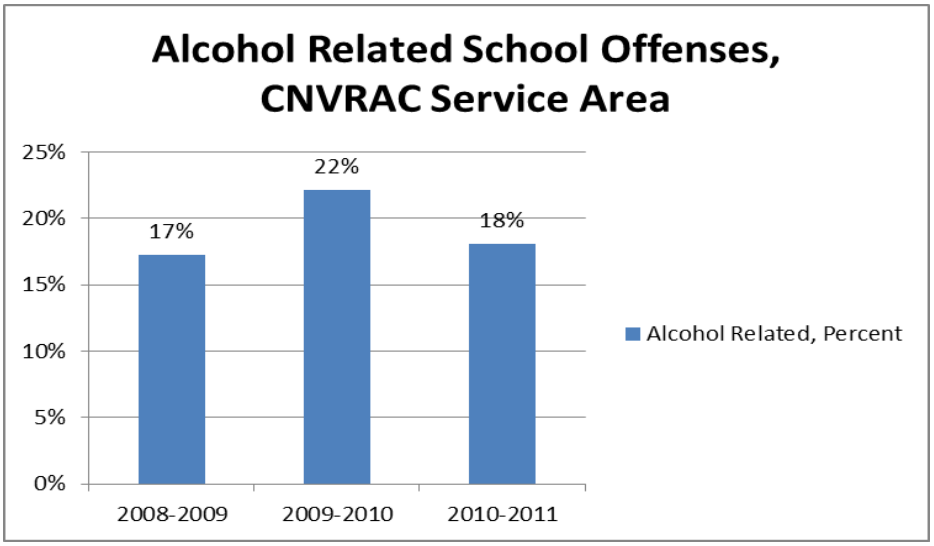
- Excessive drinking, including binge and heavy drinking, has numerous chronic and acute health effects. Chronic health consequences include: liver cirrhosis, pancreatitis, various cancers, including cancer of the liver, mouth, throat, larynx, and esophagus, high blood pressure, and psychological disorders. Acute health consequences of excessive drinking can include motor vehicle injuries, falls, domestic violence, rape, and child abuse.

CT CONSEQUENDCE DATA:

2010 Alcohol Impaired Driving Fatalities (AIDF) Data (NHTSA/FARS, 1/12)
Total Alcohol Impaired Driving Fatalities 121
Under 21 Alcohol Impaired Driving Fatalities 14
2010 Alcohol Impaired Driving Fatalities per 100,000 Population
Alcohol Impaired Driving Fatalities per 100K pop 3.4
Under 21 Alcohol Impaired Driving Fatalities per 100K pop 1.5
2000-10 Change in Alcohol Impaired Driving Fatalities per 100K pop
10-year Change in Alcohol Impaired Driving Fatalities per 100K pop ..... -9.8%
10-year Change in Under 21 Alcohol Impaired Driving Fatalities per 100K pop ..... -6.3%
Percent of Alcohol-Impaired Driving Fatalities Involving high BAC drivers (.15+)
BAC = .15+ 68.8%
Percent of Drivers in Fatal Drunk Driving Crashes Involving Repeat Offenders w/BAC .15+
BAC = .08-.14 ..... 44.4%
BAC = .15+ 55.6%
2008-09 12-20 Year Old Alcohol Consumption (latest available)
Past Month Alcohol Consumption 31.0%
Binge Drinking in Past 30-days 23.7%
2010 Arrest Data (FBI Uniform Crime Report)
Under 18: Driving under the influence 57
Total: Driving under the influence 9621
Under 18: Liquor laws 218
Total: Liquor laws 1077
Under 18: Drunkenness 0
Total: Drunkenness 1

We further know from past processes that:

- Initiation of alcohol use at young ages has been linked to more problematic levels of use in adolescence and adulthood. Young people who drink are more likely than adults to be binge drinkers.



- Heavy drinkers are at increased risk for alcohol abuse and dependence. People who begin drinking before the age of 15 are four times more likely to develop alcohol dependence than those who wait until age 21. Each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14 percent.

As with Past 30 Day Alcohol Use rates from NSDUH, we can also see that for persons needing but not receiving treatment, CT estimates are higher than national and Northeastern U.S. estimates across all age groups for 2008, 2009, and 2010.

Needing But Not Receiving Treatment for Alcohol Use in the Past Year, by Age Group and Substate Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

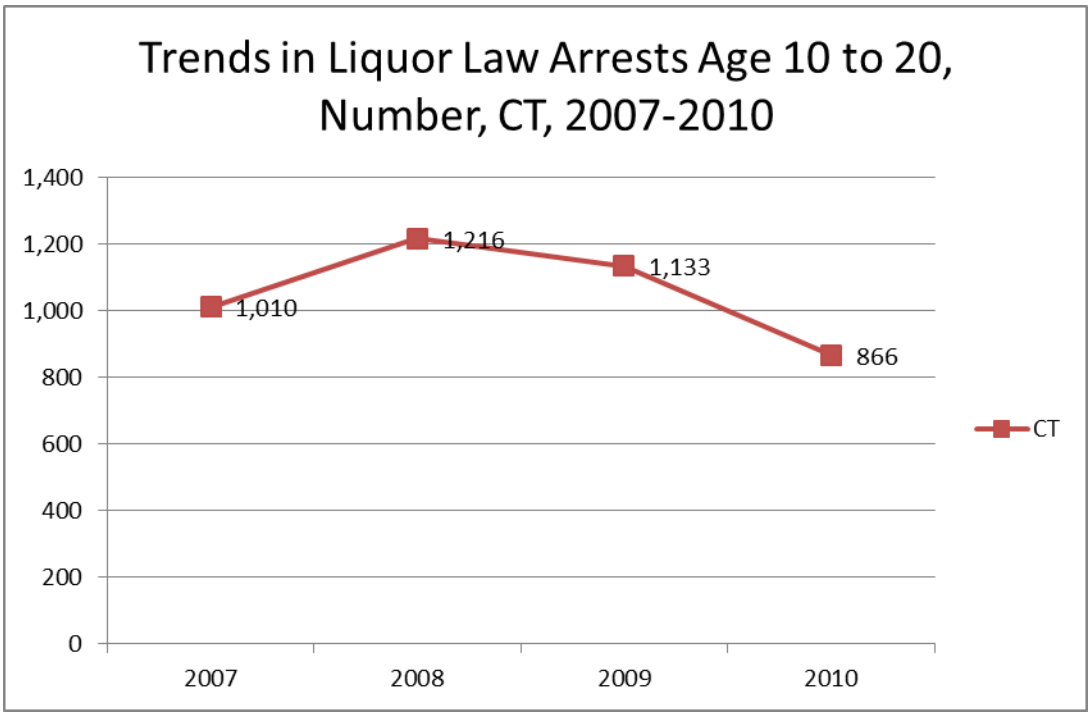
State/Substate Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	4.55	(4.33 - 4.77)	15.66	(15.27 - 16.06)	5.68	(5.46 - 5.91)	7.15	(6.95 - 7.36)
Northeast U.S.	4.55	(4.19 - 4.95)	16.63	(15.86 - 17.42)	5.54	(5.14 - 5.98)	7.14	(6.76 - 7.54)
Connecticut	5.12	(4.14 - 6.32)	18.48	(16.12 - 21.10)	6.30	(5.09 - 7.78)	7.99	(6.82 - 9.35)
Eastern	5.30	(3.69 - 7.55)	20.18	(15.85 - 25.35)	7.16	(5.15 - 9.87)	9.43	(7.37 - 11.99)
North Central	4.88	(3.61 - 6.58)	16.95	(13.68 - 20.82)	5.71	(4.21 - 7.70)	7.22	(5.76 - 9.02)
Northwestern	5.12	(3.69 - 7.08)	17.84	(14.18 - 22.21)	6.07	(4.40 - 8.33)	7.60	(5.93 - 9.69)
South Central	5.58	(4.03 - 7.67)	19.15	(15.70 - 23.16)	6.60	(4.85 - 8.93)	8.36	(6.63 - 10.48)
Southwest	4.83	(3.42 - 6.79)	19.06	(15.01 - 23.90)	6.52	(4.67 - 9.02)	8.13	(6.27 - 10.47)

Recommendations

One of the most effective ways to curb drinking, especially among young people, is to raise taxes, according to the WHO 2011 Report. Setting age limits for buying and consuming alcohol, and regulating alcohol levels in drivers, also reduce abuse if enforced. CT has regulations and policies in place that are intended to prevent underage drinking, drinking and driving, and social hosting of underage drinking parties and sales of alcohol to minors.

However, CNAW members contend that the consistent enforcement of these laws is key to their effectiveness, and that anecdotal reports of inconsistent enforcement continue to be heard. Though underage drinking and associated consequences has improved over the past decade in CT, there is still much work to be done, to continue to make headway

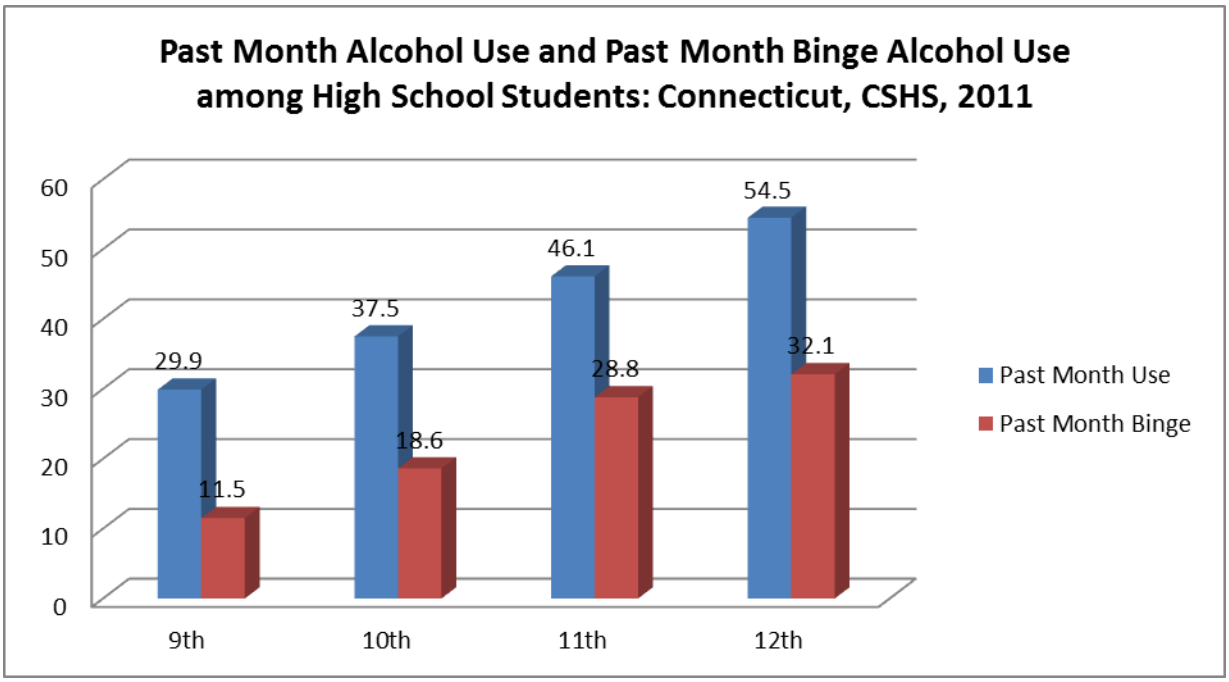
and to continue to curb and reduce underage drinking, binge alcohol use, and the consequences associated with this substance.

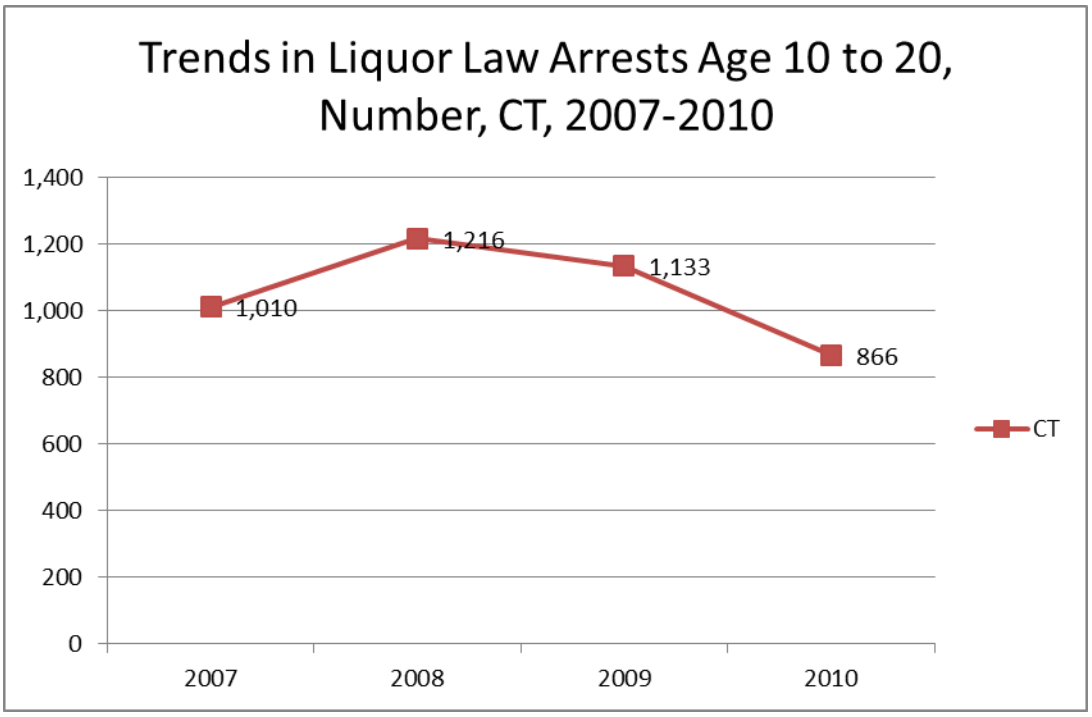


Source: Connecticut Department of Emergency Services and Public Protection Uniform Crime Reporting Program

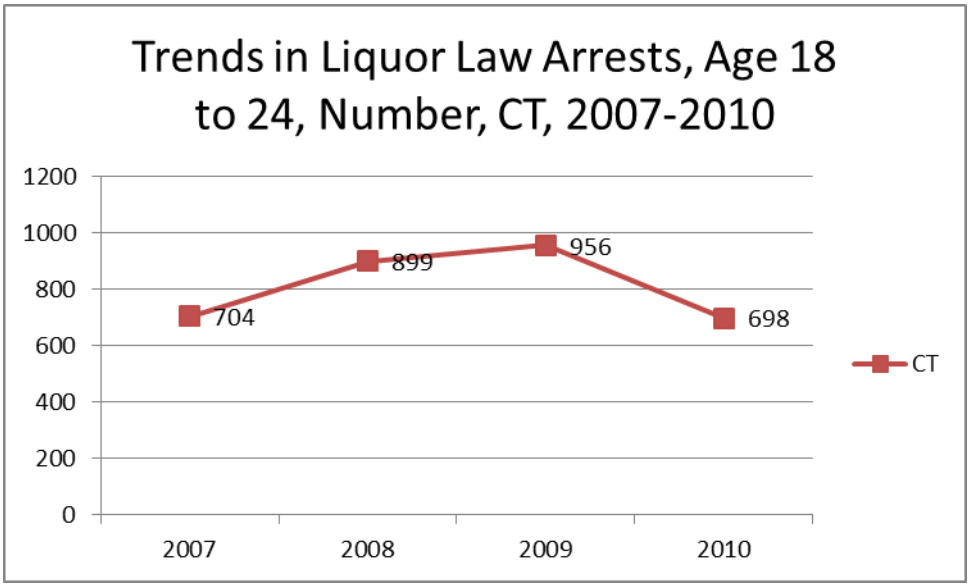
- CNAW members further recommend that the use of school strategies to provide early education and skill building should be more fully supported and increased funding should be directed to this area.
- Community education and awareness raising that reduces the commonplace acceptance of underage drinking by adults and in turn creates a supportive environment where a no-alcohol-use before age 21 message is unanimous, is also needed.
- Family strategies that provide the following, should also be increased and supported both socially and economically:
- Improved parent-child relations using positive reinforcement, listening and communication skills, and problem solving
- Provision of consistent discipline and rulemaking
- Monitoring of children's activities during adolescence
- Strengthening of family bonding

ADDITIONAL ALCOHOL RELATED DATA CHARTS & TABLES:

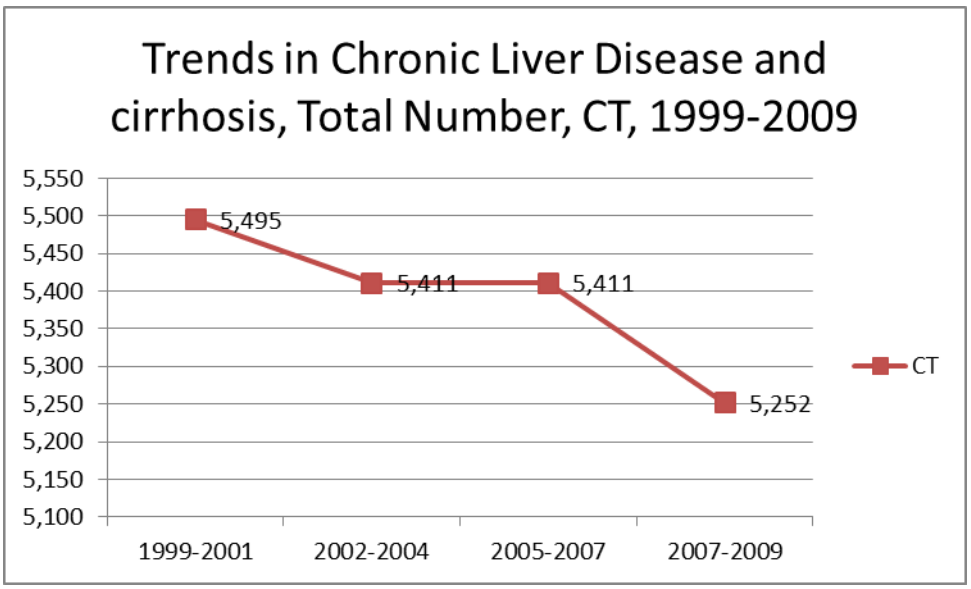




Source: Connecticut Department of Emergency Services and Public Protection Uniform Crime Reporting Program

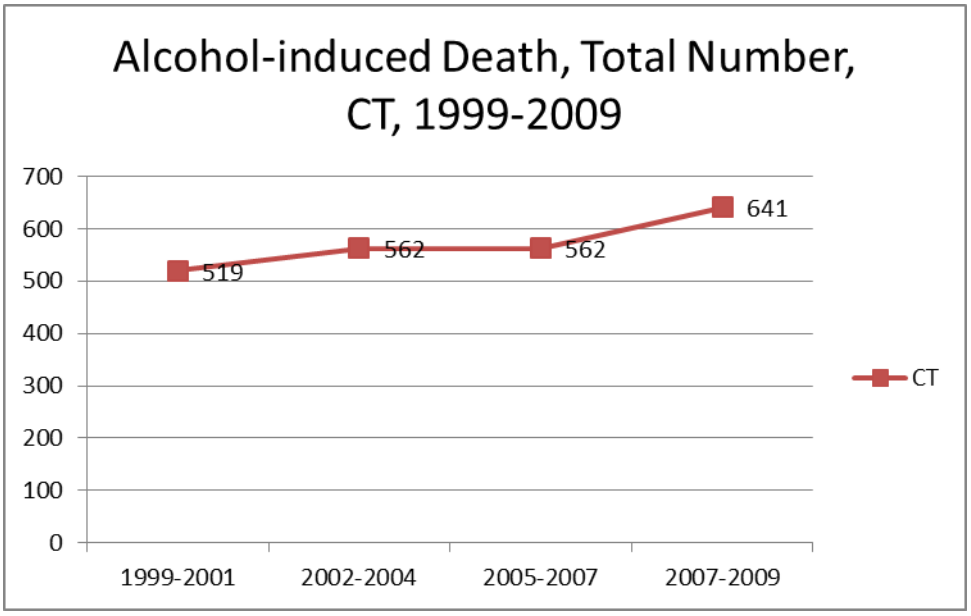


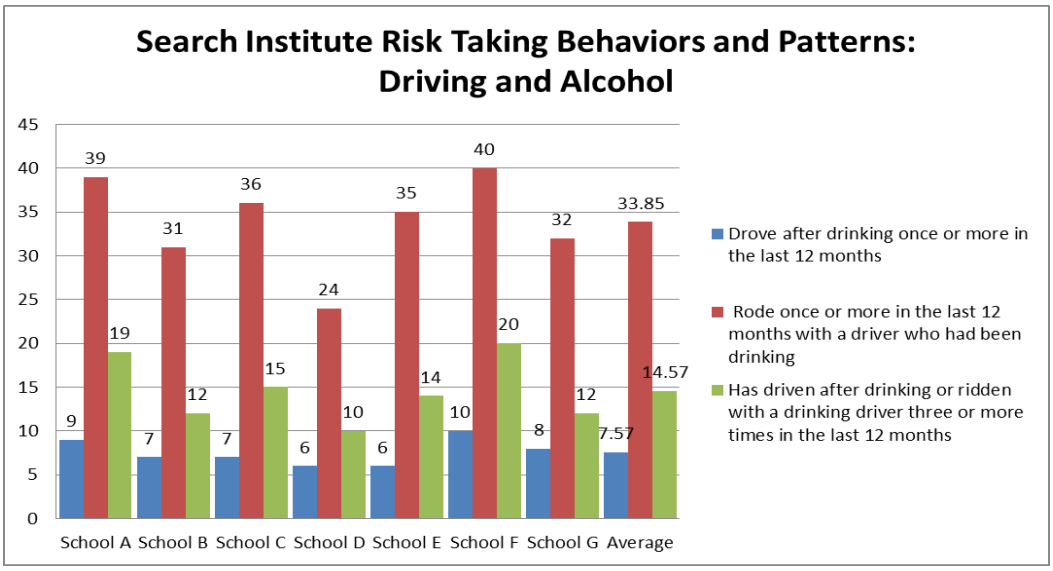
Source: Connecticut Department of Emergency Services and Public Protection Uniform Crime Reporting Program

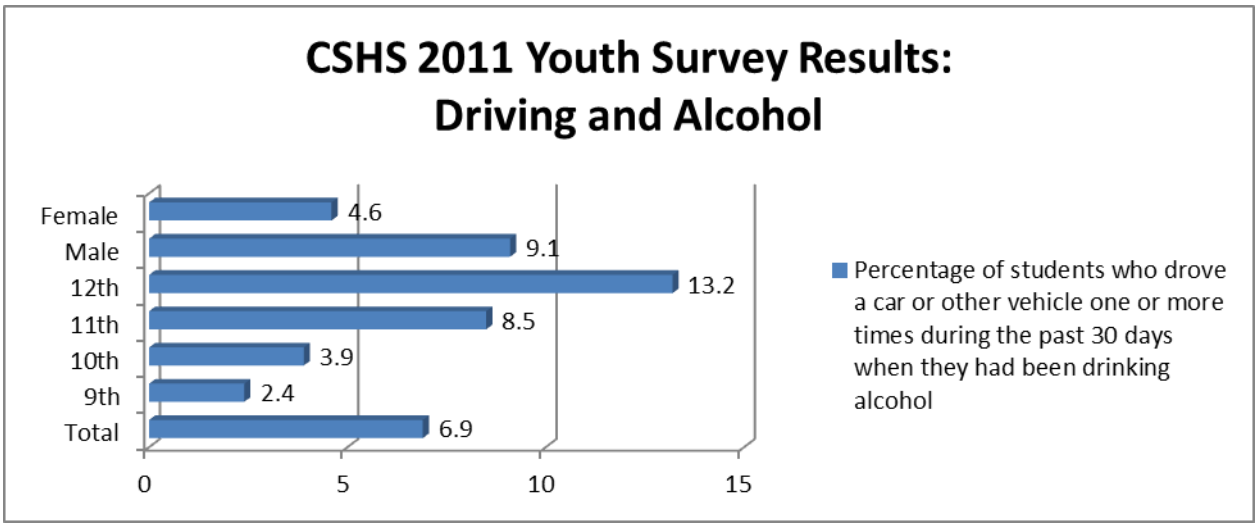


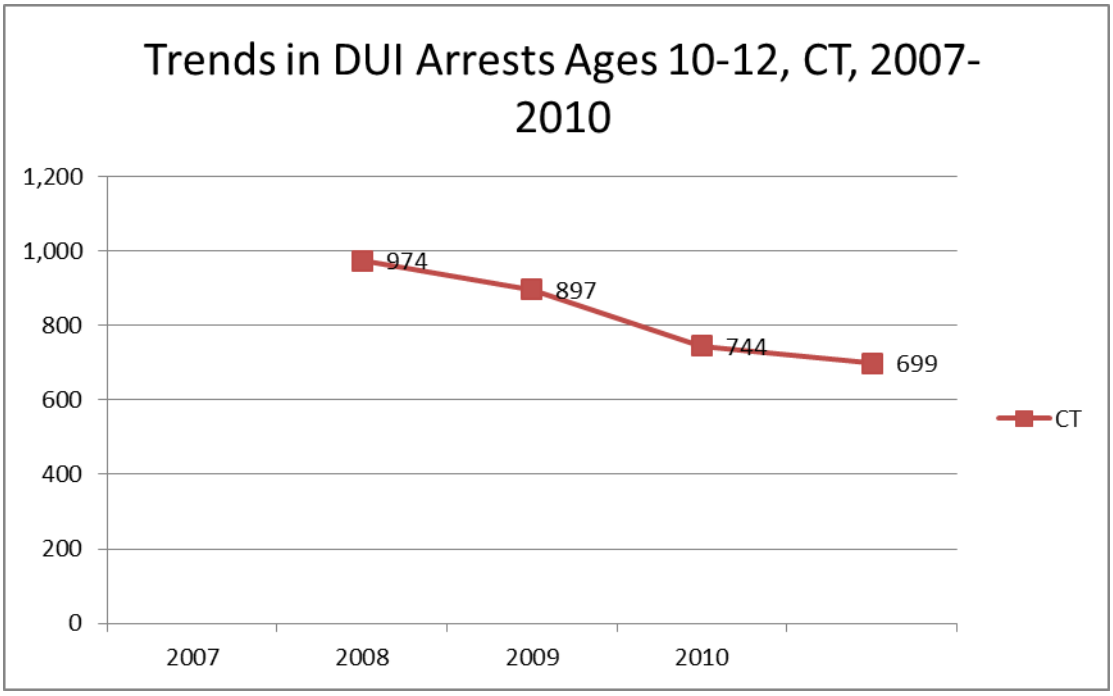
Source: Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138, Accessed 10/1/2012.

"Mortality data are some of the best sources of information about the health of living communities. They provide a snapshot of current health problems, suggest persistent patterns of risk in specific communities, and show trends in specific causes of death over time. Many causes of death are preventable or treatable and, therefore, warrant the attention of public health prevention efforts. Furthermore, because mortality data allow us to identify leading causes of premature death, they provide a valuable benchmark for evaluating progress in increasing years of healthy life for Connecticut residents. As such, they are important indicators of where federal, state, and local prevention efforts should be placed in building healthy communities." (Hynes M, et al. Mortality & Its Risk Factors in CT: 1989-1998, p. I-3)

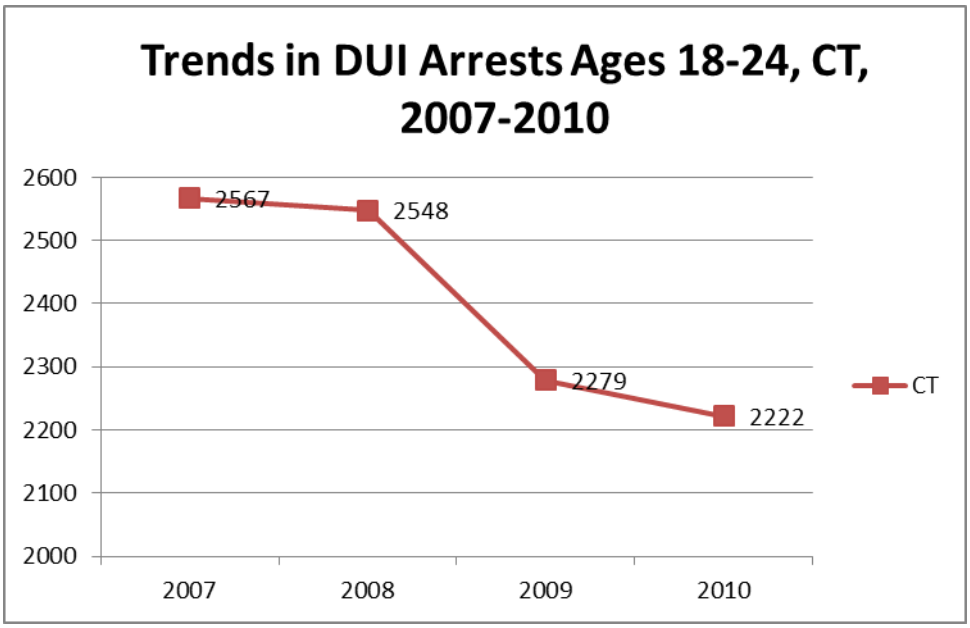

Alcohol-induced Death, Total Number, CT, 1999-2009
700
600
500
400
300
200
100
0
519
562
562
641
1999-2001
2002-2004
2005-2007
2007-2009
CT


Search Institute Risk Taking Behaviors and Patterns: Driving and Alcohol
45
40
35
30
25
20
15
10
5
0
9
39
19
7
31
12
7
36
15
6
24
10
6
35
14
10
40
20
8
32
12
7.57
33.85
14.57
School A
School B
School C
School D
School E
School F
School G
Average
Drove after drinking once or more in the last 12 months
Rode once or more in the last 12 months with a driver who had been drinking
Has driven after drinking or ridden with a drinking driver three or more times in the last 12 months

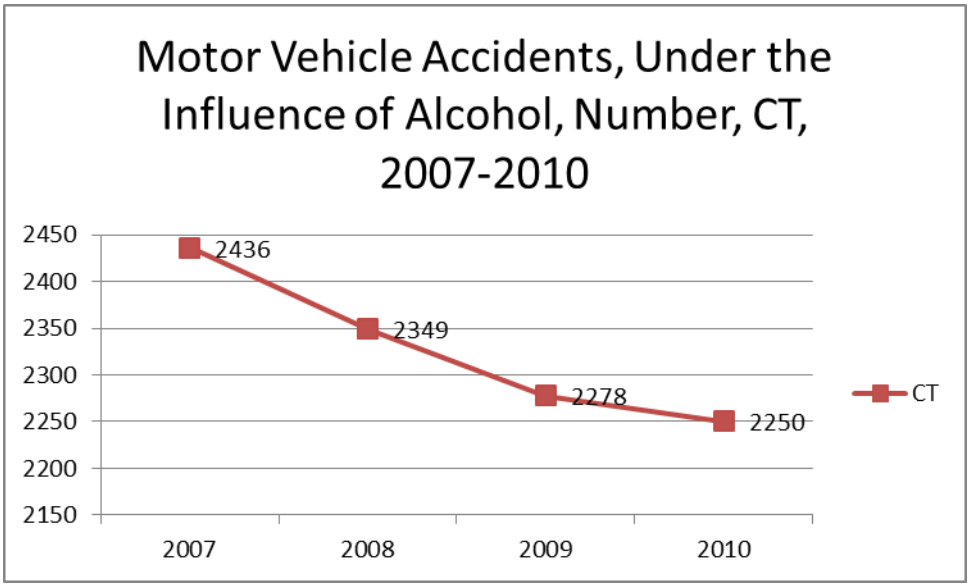

CSHS 2011 Youth Survey Results: Driving and Alcohol
Female
Male
12th
11th
10th
9th
Total
4.6
9.1
13.2
8.5
3.9
2.4
6.9
0
5
10
15
Percentage of students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol

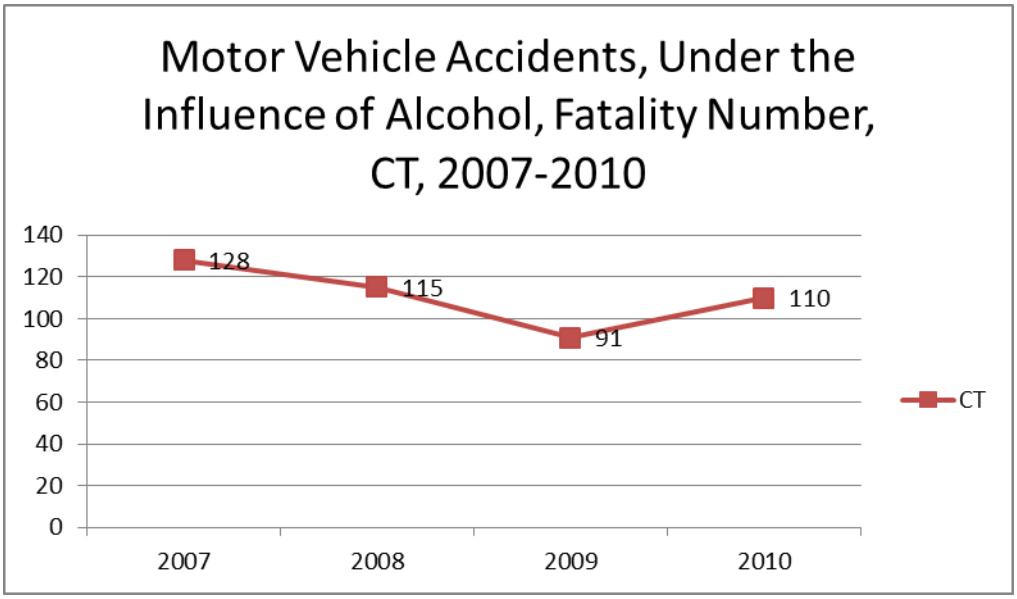


Source: Connecticut Department of Emergency Services and Public Protection Uniform Crime Reporting Program



Source: Connecticut Department of Emergency Services and Public Protection Uniform Crime Reporting Program





Source: The Fatality Analysis Reporting System, National Highway Traffic Safety Administration

FARS is a steady state crash data collection and analysis program. FARS collects State level data for analysis of traffic safety crashes to identify problems and evaluate countermeasures designed to reduce injuries and property damage resulting from motor vehicle crashes. The data are used for agency rulemaking and targeting grant money to areas most in need. The types of data collected can be used specifically to conduct research on ways to remediate problems such as alcohol involvement, vehicle types, weather and road conditions, seat belt use, car seats, air bags. The program provides analytical data and information to the public through various media, including the program's web services.

Prevention Priority 2: Marijuana

Magnitude

Marijuana remains the most commonly used illicit drug in Connecticut and in the United States.

A December 2011 Center for Substance Abuse Research (CESAR Fax) Report revealed that early marijuana use is related to later substance use disorders. According to data from NSDUH, adults who first used marijuana before age 14 or younger were more than twice as likely to meet the criteria for past year illicit drug abuse or dependence than those who first used marijuana between the ages of 15 and 17, and nearly five times more likely than those who started when they were 18 or older.

A May 2012 CESAR Report indicated that nearly one in ten (9%) U.S. high school students reported heavy marijuana use (20 times or more) in the past month, according to recently released data from the 2011 Partnership Attitude Tracking Study.

An October 2012 CESAR Report states that an estimated 3.1 million persons ages 12 and older—an average of approximately 8,400 per day—used a drug other than alcohol for the first time in the past year, according to data from the 2011 National Survey on Drug Use and Health. More than two-thirds (68%) of these new users reported that marijuana was the first drug they tried.

A changing landscape:
According to NSDUH, past-month marijuana use among 12- to 17-year olds climbed 9% from 2008 to 2009, and not surprisingly, this increase coincided with a softening of youth attitudes about the risks of marijuana. Since CT's last priority setting process (2010), possession of small amounts of marijuana were decriminalized by the state, leaving many misinformed users believing that decriminalization means that the substance is now legal. The June 2011 legislation may have further paved the way for the recent passage of a medical marijuana act here in the state. On May 31, 2012 Connecticut became the 17th medical marijuana state. These recent acts have made arguments about the harmful effects of marijuana use, harder to validate to some populations. Across the CNVRAC service area, community members have reported having mixed opinions about the legislation changes and their potential impact on the prevention of substance abuse across the lifespan.

Marijuana Use in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	13.67	(13.30 - 14.05)	29.42	(28.87 - 29.98)	7.65	(7.37 - 7.94)	10.86	(10.59 - 11.13)
Northeast U.S.	14.48	(13.80 - 15.18)	34.28	(33.22 - 35.35)	8.24	(7.71 - 8.81)	11.99	(11.49 - 12.51)
Connecticut	16.22	(14.11 - 18.58)	36.86	(33.59 - 40.24)	8.78	(7.23 - 10.62)	12.67	(11.15 - 14.37)
Eastern	14.64	(10.84 - 19.49)	*	(* - *)	8.85	(6.23 - 12.43)	13.34	(10.36 - 17.02)
North Central	17.26	(14.01 - 21.07)	40.31	(34.80 - 46.08)	9.66	(7.29 - 12.69)	13.78	(11.35 - 16.64)
Northwestern	15.50	(12.08 - 19.68)	36.20	(30.02 - 42.87)	8.34	(6.01 - 11.47)	11.95	(9.41 - 15.07)
South Central	18.85	(14.96 - 23.47)	40.48	(35.08 - 46.12)	9.79	(7.35 - 12.92)	14.08	(11.58 - 17.01)
Southwest	13.35	(10.11 - 17.43)	*	(* - *)	6.51	(4.51 - 9.31)	9.38	(7.13 - 12.24)

* Low precision; no estimate reported.

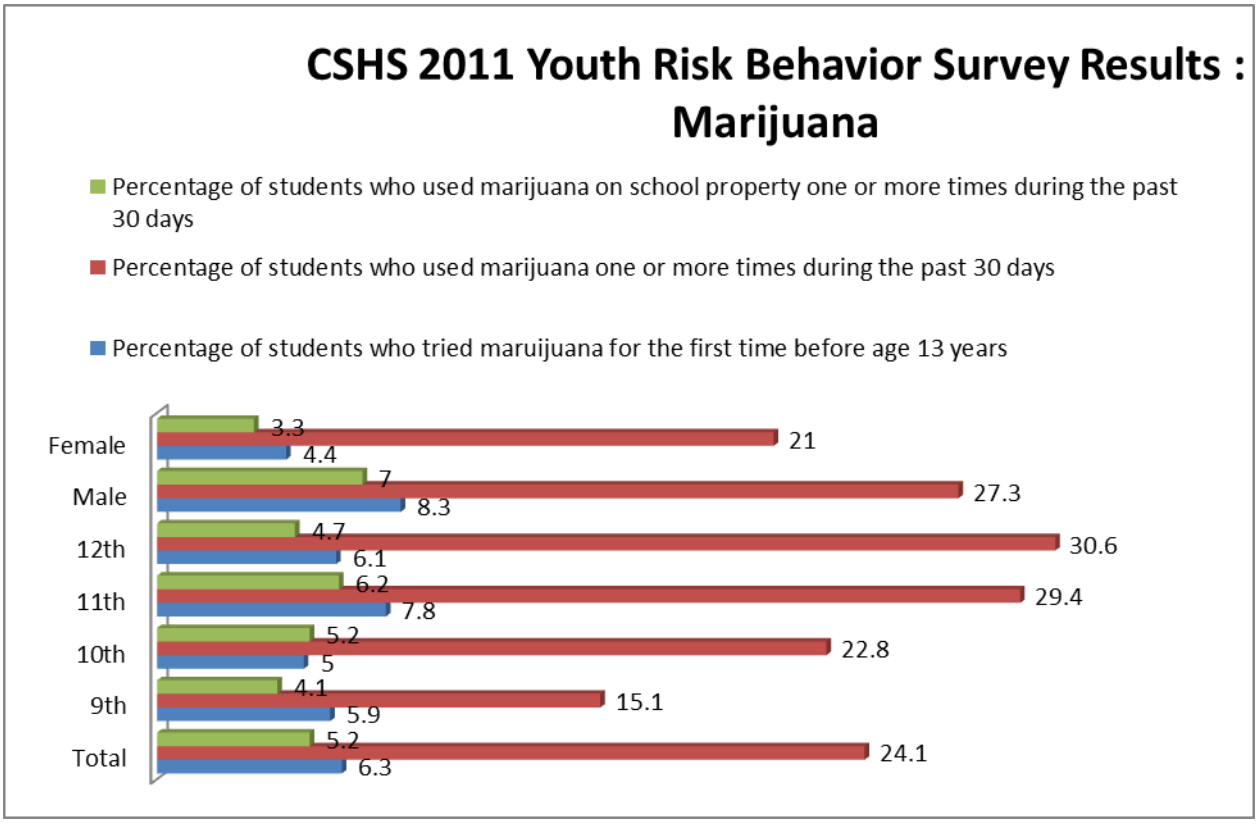
Marijuana Use in the Past Month, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	7.19	(6.91 - 7.47)	17.71	(17.27 - 18.16)	4.58	(4.37 - 4.80)	6.52	(6.32 - 6.73)
Northeast U.S.	8.28	(7.73 - 8.86)	21.33	(20.39 - 22.31)	4.82	(4.43 - 5.25)	7.20	(6.82 - 7.59)
Connecticut	8.80	(7.23 - 10.66)	22.22	(19.47 - 25.24)	5.03	(3.91 - 6.46)	7.42	(6.26 - 8.76)
Eastern	8.87	(6.10 - 12.74)	*	(* - *)	6.38	(4.17 - 9.65)	9.01	(6.54 - 12.29)
North Central	8.39	(6.28 - 11.13)	23.35	(19.03 - 28.31)	4.98	(3.51 - 7.01)	7.45	(5.84 - 9.46)

Marijuana Use in the Past Month, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs								
State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Northwestern	9.86	(7.06 - 13.61)	22.30	(17.41 - 28.10)	5.19	(3.49 - 7.66)	7.41	(5.53 - 9.86)
South Central	9.47	(6.98 - 12.73)	23.85	(19.44 - 28.91)	5.29	(3.68 - 7.55)	7.89	(6.14 - 10.07)
Southwest	7.58	(5.31 - 10.71)	18.74	(13.99 - 24.64)	3.77	(2.39 - 5.91)	5.69	(4.08 - 7.90)
* Low precision; no estimate reported.								

Marijuana use is widespread among young adults and adolescents. The 2012 Core Survey of college students across the U.S. showed that 31.3% of students admitted smoking marijuana in the past year and 18.1% had used marijuana in the past month. The 2011 NSDUH survey reported marijuana use among the similar age demographic of CT 18-25 year olds as 36.8% in the past year and 22.2% in the past month, both higher than national and CORE survey figures.

The 2007 Connecticut High School YRBSS survey results demonstrate that while fewer students report use of marijuana as compared to alcohol, there is still a significant number of students currently smoking marijuana within the past month with 15.1% of 9th graders and 30.6% of 12th graders reporting current use. The rates of past 30 day marijuana use percentages by race/ethnicities varies minimally. However, by gender, 27.3% of CT's male high school students report past 30 day use while only 21% of CT's female high school students report past 30 day use.

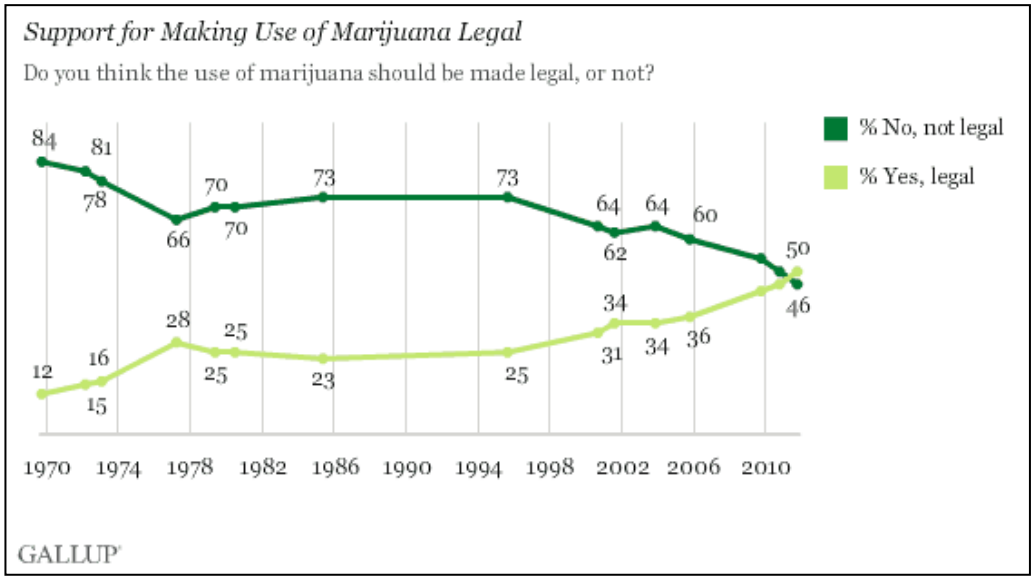


GALLUP POLE ARTICLE:

Record-High 50% of Americans Favor Legalizing Marijuana Use;Liberals and those 18 to 29 most in favor; Americans 65 and older most opposed

by Frank Newport

PRINCETON, NJ -- A record-high 50% of Americans now say the use of marijuana should be made legal, up from 46% last year. Forty-six percent say marijuana use should remain illegal.



When Gallup first asked about legalizing marijuana, in 1969, 12% of Americans favored it, while 84% were opposed. Support remained in the mid-20s in Gallup measures from the late 1970s to the mid-1990s, but has crept up since, passing 30% in 2000 and 40% in 2009 before reaching the 50% level in this year's Oct. 6-9 annual Crime survey.

According to the National Institute on Drug Abuse, "Marijuana is the most commonly abused illicit drug in the United States." The National Survey on Drug Use and Health in 2009 found that "16.7 million Americans aged 12 or older used marijuana at least once in the month prior to being surveyed, an increase over the rates reported in all years between 2002 and 2008."

Support for Legalizing Use of Marijuana, by Subgroup

	% Yes, legal
Liberals	69
18 to 29	62
Moderates	57
Independents	57
Democrats	57
30 to 49	56
West	55
Men	55
Midwest	54
East	51
50 to 64	49
Women	46
South	44
Republicans	35
Conservatives	34
65+	31

Oct. 6-9, 2011

GALLUP

The advocacy group National Organization for the Reform of Marijuana Laws claims that marijuana is the third-most-popular recreational drug in America, behind only alcohol and tobacco. Some states have decriminalized marijuana's use, some have made it legal for medicinal use, and some officials, including former U.S. Surgeon General Joycelyn Elders, have called for legalizing its use.

A Gallup survey last year found that 70% favored making it legal for doctors to prescribe marijuana in order to reduce pain and suffering. Americans have consistently been more likely to favor the use of marijuana for medicinal purposes than to favor its legalization generally.

Younger Americans Most in Favor of Legalizing Marijuana

Support for legalizing marijuana is directly and inversely proportional to age, ranging from 62% approval among those 18 to 29 down to 31% among those 65 and older. Liberals are twice as likely as conservatives to favor legalizing marijuana. And Democrats and independents are more likely to be in favor than are Republicans.

More men than women support legalizing the drug. Those in the West and Midwest are more likely to favor it than those in the South.

Bottom Line

Support for legalizing marijuana has been increasing over the past several years, rising to 50% today -- the highest on record. If this current trend on legalizing marijuana continues, pressure may build to bring the nation's laws into compliance with the people's wishes.

Impact

- Smoking marijuana frequently has been associated with increased reporting of health problems and more days of missed employment than nonsmokers.
- In the short-term marijuana use may cause adverse physical, mental, emotional, and behavioral changes such as problems with memory and learning, distorted perception, difficulty in thinking and problem solving, loss of coordination, and increased heart rate.
- Longer term adverse health effects include respiratory illnesses, memory impairment, and weakening of the immune system. Long-term marijuana use causes changes in the brain similar to those seen after long-term use of other major drugs of abuse.
- Marijuana has been shown to compromise the ability to learn and remember information, often leading to deficits in accumulating intellectual, job or social skills.
- Depression, anxiety, and personality disturbances have been associated with marijuana use.
- Babies born to women who used marijuana during their pregnancies display altered responses to visual stimuli, increased tremulousness, and potential neurological problems.
- Risk of heart attack more than quadruples in the first hour after smoking marijuana.
- Initiation of marijuana use at younger ages has been linked to higher and more severe patterns of use of marijuana and other substances in adolescence and adulthood.
- Based on administrative data reported by Connecticut to TEDS (Treatment Episode Data Set) & SAMHSA, marijuana was the third highest primary substance that individuals (7828 persons) presented to treatment for in 2011.
- Although marijuana abusers generally do not commit violent crimes, the distribution of marijuana has been associated with violent crime in Connecticut, usually involving rival criminal groups and gangs.
- The social costs of marijuana use were estimated at $9.1 billion in 2001.

Recommendation

Ongoing monitoring of regulations regarding medical marijuana; continue education about harmful effects of marijuana on brain development as well as awareness raising of drugged driving concerns and marijuana as gateway drug.

Prevention Priority 3: Prescription Drugs

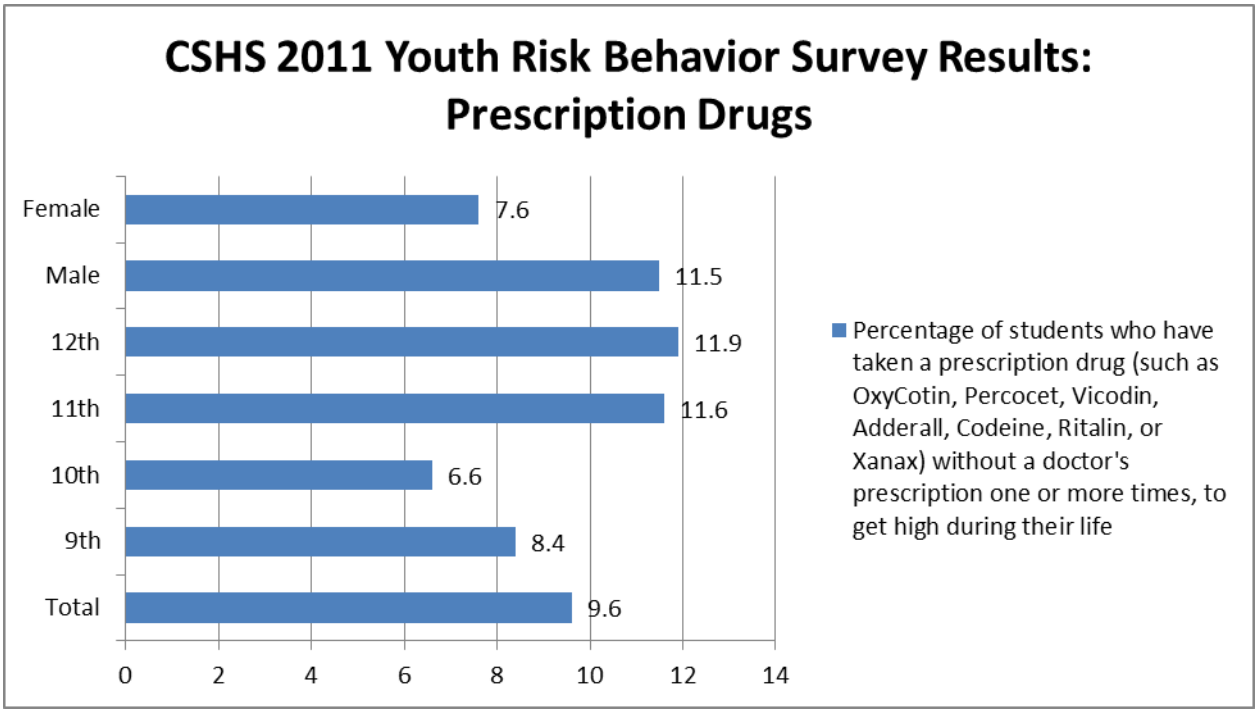
Magnitude

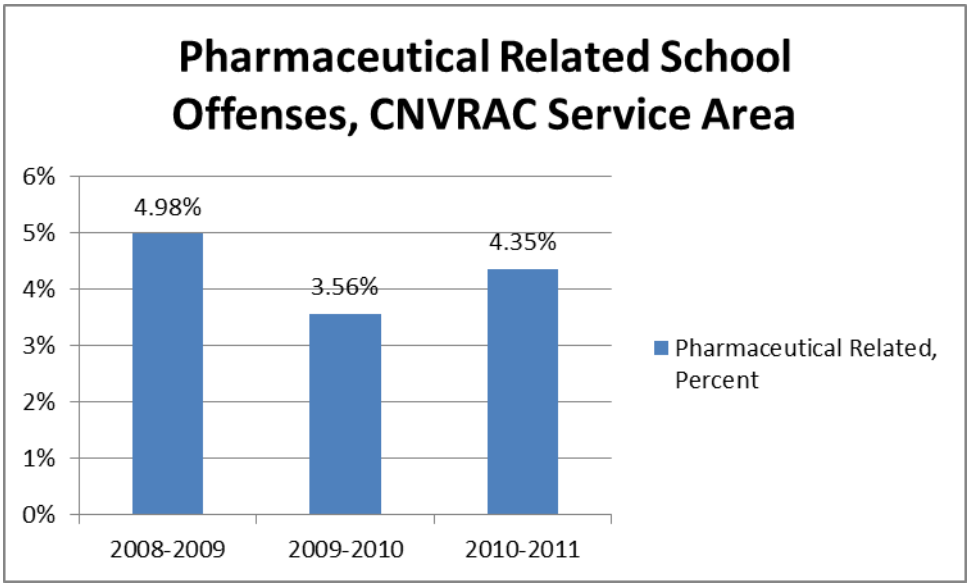
The 2010 National Survey of Drug Use and Health (NSDUH) found that 4.8% of the US population aged 12 and older were currently using prescription pain relievers non-medically, 2.2% of the population were using sedatives and tranquilizers non-medically, and 1.1% were using prescription stimulants, non-medically Young adults represented the fastest growing segment of the population abusing prescription and over the counter drugs.

The University of Michigan's 2011 Monitoring the Future study results found that of U.S. 12th graders, the following percentages of past year non-medical pharmaceutical use were reported: 8.1% Vicodin, 6.5% Adderall, 5.6% tranquilizers, 5.3% cough medicine, 4.9% Oxycontin, 4.3% sedatives, and 2.6% Ritalin.

Treatment providers note that misuse of prescription pain medications is linked to later use of heroin and they are seeing an increase in the number of clients who are presenting with heroin at treatment admissions. Also, misuse of prescription drugs is common among the elderly, who use prescription medications approximately three times as frequently as the general population.

CT School Health Survey Data (2011) shows that 9.6% of high school youth have taken a prescription drug one or more times in their life, without a doctor's prescription, to get high. This percentage response has not changed since 2009. Locally, only one community has recent data comparable to the state survey sample, where 11% of 12th graders reported past 30 day use, and for CSHS 11.9% of 12th graders reported lifetime use.





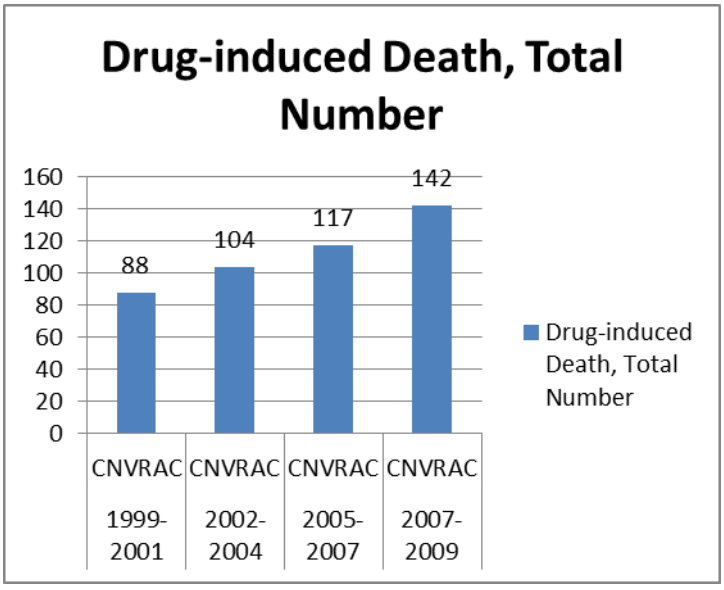
And, according to Monitoring the Future's 2009-2011combined annual averages, 70% of 12th graders across the nation who obtain the prescription narcotics for misuse, are given these drugs free, from a friend or relative.

Misuse of prescription drugs may also be the most common form of drug abuse among the elderly who use prescription medications approximately three times as frequently as the general population and have been found to have the poorest rates of compliance with directions for taking a medication.

Data from Connecticut's substance abuse treatment system show that there were 4471 primary prescription drug abuse treatment admissions in 2011, representing 7% of all treatment admissions statewide. From 2.3% of primary prescription drug abuse treatment admissions in 2003 this represents a 304% increase to 2011.

Impact & Consequences (according to past and current priority setting processes)

- Negative health consequences include the potential for developing tolerance to the drug, physical dependence.
- Severe respiratory depression, cardiovascular failure, seizures or death can follow a large single dose of a prescription drug.
- The CDC's Morbidity and Mortality Weekly Report (2011) found that deaths from opioid pain relievers exceeded those from all illegal drugs.



- Abuse of controlled prescription drugs is implicated in at least 23% of drug-related emergency department admissions and 20% of all single drug-related emergency department deaths. Between 1994 and 2002, there was a 79% increase in the total number of controlled prescription drug related mentions in emergency department visits, with prescription opioids demonstrating the sharpest increase (168%) over this period.

- Prescription opioids accounted for more drug mentions involved in multiple drug-related deaths (19%) than cocaine (15%), heroin (13%) and marijuana (3%).

- Seven percent of all controlled prescription drug abusers report experiencing emotional or mental health problems caused or worsened by their abuse of the drugs.

- Twelve percent of adult prescription drug abusers and 15% of teenage prescription drug abusers meet DSM-IV diagnostic criteria for abuse or addiction to these drugs.

- It has been estimated that the cost of opioids analgesic abuse in the US in 2001 was $9.2 billion.

Recommendations

Ongoing monitoring of school and treatment data; maintain efforts in the area of education, law enforcement, and treatment capacity.

Collaboration with existing efforts to prevent prescription and over-the-counter drug abuse, which is essential to ensuring patients do not become addicts, should continue.

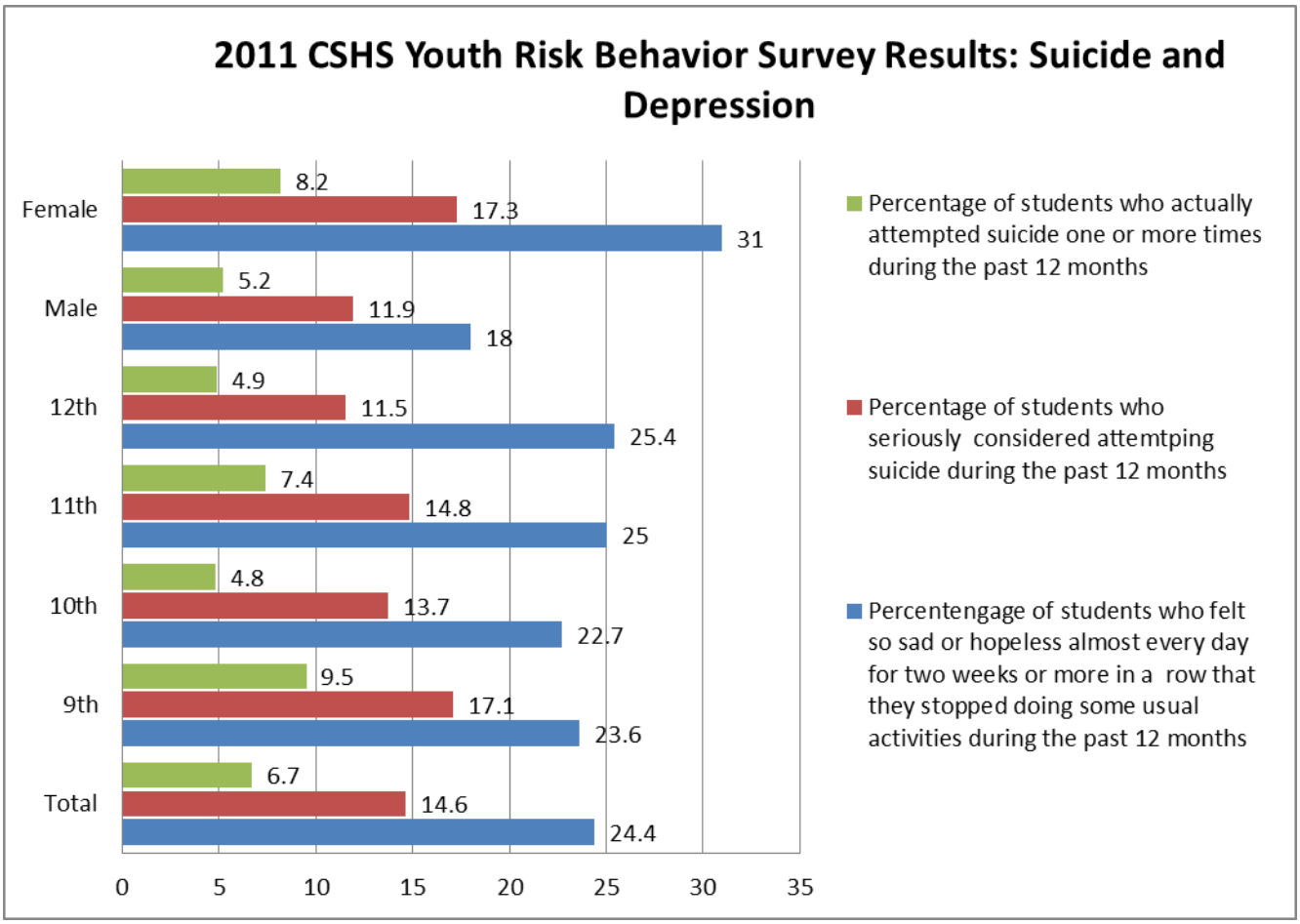
CNVRAC should continue to support Medication Take Back programs on the local, regional and statewide level to allow community members to safely dispose of to all prescription and over the counter medications and educate the public to the dangers of prescription medication abuse.

Prevention Priority 4: Suicide

Magnitude

Results from the 2011 CT School Health Survey report that among high school students:

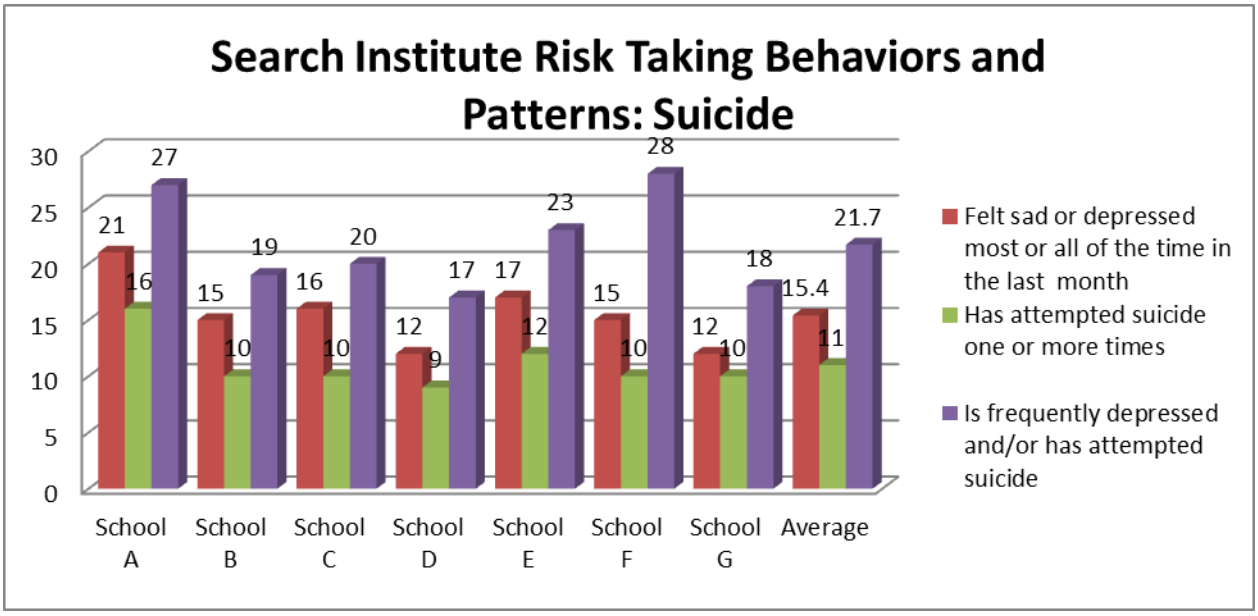
- 24.4% felt sad or hopeless for more than 2 weeks
- 14.6% seriously considered attempting suicide
- 6.7% actually attempted suicide



For CDC National Suicide Facts at a Glance 2012, please visit:
http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.PDF

For CT Youth Suicide Report (Duarte 8/27/2009), please visit:
http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/YouthSuicideCT.pdf

According to CNVRAC local-level data from school surveys conducted with youth in grades 6-12, anywhere between 12-21% of those surveyed reported feeling sad or depressed most or all of the time in the last month). Across this same sample, between 9-16% of youth have attempted suicide one or more times. And the high-risk behavior pattern of feeling frequently depressed and/or having attempted suicide is between 17-28% of the sample.



Recommendations

Suicide as a result of bullying (including cyber bullying) is an area that should receive more resources to effectively intervene when self-injury and attempted suicide take place.

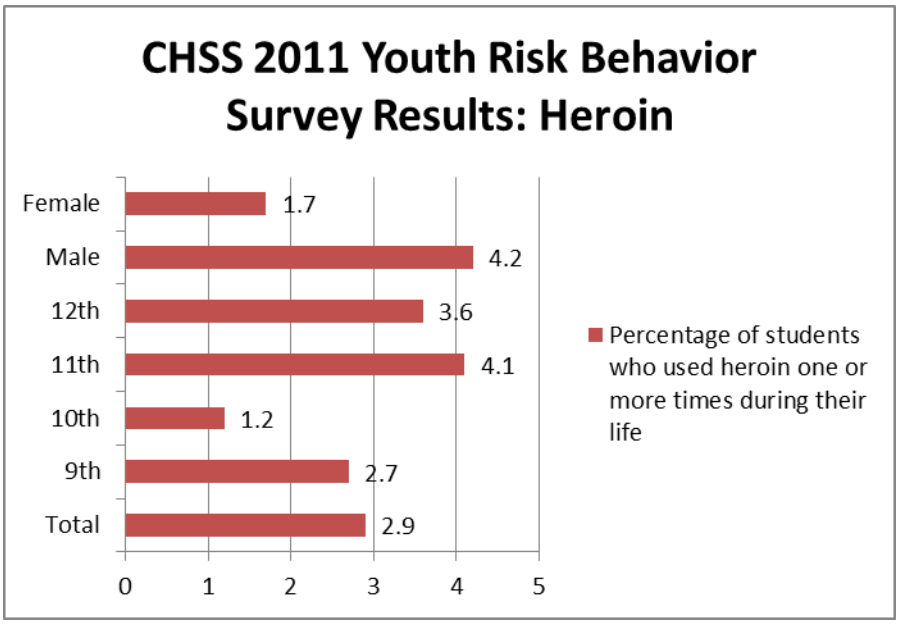
Assistance in gathering current, accurate local data and information about the nature and extent of suicide and self-injury should continue.

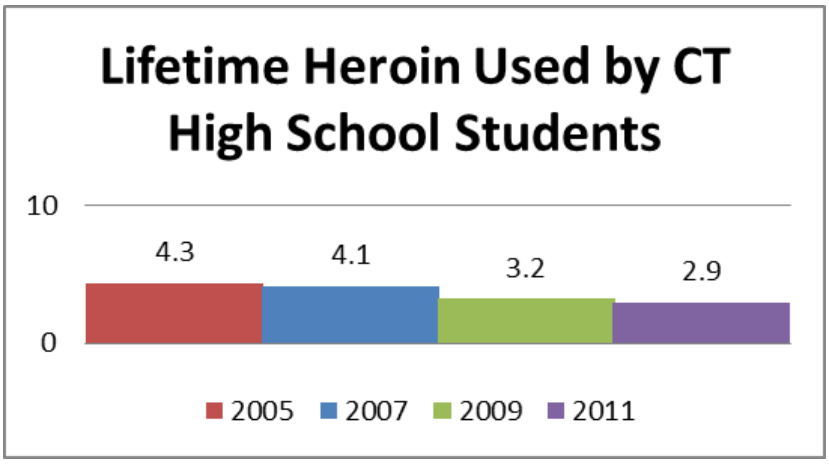
Easy access to clinical interventions and support for help-seeking should be increased.

Prevention Priority 5: Heroin

Magnitude

- According to the 2010 National Survey on Drug Use and Health (NSDUH), there were 140,000 persons aged 12 or older who had used heroin for the first time within the past 12 months. This estimate was similar to the estimate in 2009 (180,000) and to estimates during 2002 to 2008 (ranging from 91,000 to 118,000 per year). The average age at first use among recent initiates aged 12 to 49 was 21.3 years, significantly lower than the 2009 estimate (25.5 years).
- From 2002 to 2010 heroin was the least perceived available drug of all illicit substances reported, lower than marijuana, cocaine and LSD.
- According to SAMHSA's Treatment Episode Data Set, 24.9% of all substance abuse treatment admissions in CT were for heroin as the primary substance of abuse. This is a decrease compared to 2006, where 36% of CT treatment admissions were due to the use of heroin as a primary substance.
- Demand for heroin increased dramatically in Connecticut in the last decade. It is now easily accessible, of high purity (an average of 70-80% purity according to the DEA) and sells at low prices.
- The 2011 YRBSS Student Survey found that 2.9% of 9th-12th graders reported ever using heroin and that lifetime use by CT high school students has steadily decreased since 2005.





Illicit Drug Dependence or Abuse in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs								
State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	4.59	(4.38 - 4.81)	7.81	(7.53 - 8.09)	1.73	(1.62 - 1.86)	2.63	(2.52 - 2.75)
Northeast U.S.	4.46	(4.09 - 4.85)	8.84	(8.28 - 9.43)	1.80	(1.58 - 2.05)	2.81	(2.59 - 3.06)
Connecticut	4.39	(3.45 - 5.57)	8.75	(7.20 - 10.60)	1.75	(1.22 - 2.50)	2.72	(2.14 - 3.46)
Eastern	4.20	(2.69 - 6.50)	7.62	(5.32 - 10.79)	1.65	(0.90 - 2.97)	2.69	(1.78 - 4.03)
North Central	4.00	(2.76 - 5.76)	8.16	(6.12 - 10.81)	1.63	(0.98 - 2.69)	2.50	(1.77 - 3.54)
Northwestern	5.30	(3.52 - 7.90)	9.42	(6.81 - 12.89)	2.00	(1.15 - 3.45)	2.96	(1.99 - 4.37)
South Central	4.52	(3.03 - 6.68)	9.66	(7.25 - 12.76)	1.90	(1.13 - 3.18)	2.99	(2.11 - 4.22)
Southwest	4.09	(2.62 - 6.31)	8.83	(6.27 - 12.30)	1.58	(0.88 - 2.81)	2.51	(1.67 - 3.76)

Illicit Drug Dependence in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs								
State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	2.50	(2.35 - 2.67)	5.51	(5.27 - 5.75)	1.24	(1.14 - 1.34)	1.87	(1.78 - 1.97)
Northeast U.S.	2.54	(2.29 - 2.83)	6.51	(6.02 - 7.05)	1.38	(1.20 - 1.59)	2.12	(1.93 - 2.33)
Connecticut	2.55	(1.90 - 3.41)	5.80	(4.57 - 7.35)	1.29	(0.88 - 1.88)	1.91	(1.45 - 2.52)
Eastern	2.44	(1.38 - 4.30)	4.96	(3.30 - 7.38)	1.19	(0.65 - 2.16)	1.84	(1.19 - 2.85)
North Central	2.50	(1.54 - 4.05)	5.50	(3.89 - 7.72)	1.25	(0.73 - 2.14)	1.82	(1.23 - 2.70)
Northwestern	3.24	(1.90 - 5.47)	6.22	(4.36 - 8.79)	1.49	(0.82 - 2.71)	2.11	(1.36 - 3.25)
South Central	2.35	(1.33 - 4.11)	6.58	(4.76 - 9.01)	1.35	(0.78 - 2.33)	2.08	(1.42 - 3.03)
Southwest	2.27	(1.29 - 3.95)	5.58	(3.76 - 8.20)	1.13	(0.61 - 2.07)	1.70	(1.08 - 2.66)

NOTE: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but not receiving treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

Illicit Drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type psychotherapeutics used non-medically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

See Section B.4.8 in Appendix B of the Results from the 2008 National Survey on Drug Use and Health: National Findings.

Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs								
State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	7.40	(7.13 - 7.68)	20.31	(19.87 - 20.75)	7.11	(6.86 - 7.36)	9.05	(8.83 - 9.29)
Northeast U.S.	7.45	(6.98 - 7.95)	21.86	(20.97 - 22.78)	7.10	(6.62 - 7.61)	9.22	(8.79 - 9.67)
Connecticut	7.47	(6.12 - 9.10)	22.85	(20.31 - 25.60)	7.47	(6.09 - 9.12)	9.60	(8.29 - 11.10)
Eastern	7.75	(5.35 - 11.12)	23.77	(19.10 - 29.18)	8.25	(5.89 - 11.43)	10.95	(8.58 - 13.89)
North Central	6.59	(4.83 - 8.94)	20.95	(17.43 - 24.98)	6.76	(4.99 - 9.10)	8.67	(6.92 - 10.81)
Northwestern	7.89	(5.63 - 10.96)	22.64	(18.45 - 27.45)	7.41	(5.41 - 10.09)	9.39	(7.39 - 11.86)
South Central	8.22	(5.97 - 11.22)	24.59	(20.62 - 29.05)	7.81	(5.86 - 10.35)	10.16	(8.25 - 12.45)
Southwest	7.32	(5.26 - 10.08)	22.82	(18.31 - 28.06)	7.67	(5.53 - 10.54)	9.61	(7.45 - 12.31)

Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs								
State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	4.28	(4.08 - 4.49)	7.16	(6.89 - 7.44)	1.52	(1.41 - 1.63)	2.35	(2.24 - 2.46)
Northeast U.S.	4.15	(3.80 - 4.52)	7.95	(7.42 - 8.51)	1.51	(1.32 - 1.72)	2.44	(2.24 - 2.65)
Connecticut	4.03	(3.16 - 5.13)	7.56	(6.10 - 9.34)	1.40	(0.97 - 2.01)	2.25	(1.76 - 2.88)
Eastern	3.90	(2.53 - 5.97)	6.86	(4.76 - 9.80)	1.40	(0.80 - 2.45)	2.35	(1.59 - 3.47)
North Central	3.73	(2.57 - 5.39)	7.24	(5.24 - 9.92)	1.37	(0.81 - 2.30)	2.16	(1.49 - 3.10)
Northwestern	4.77	(3.24 - 6.97)	8.07	(5.75 - 11.20)	1.43	(0.83 - 2.46)	2.29	(1.56 - 3.35)
South Central	4.09	(2.74 - 6.06)	7.95	(5.86 - 10.70)	1.54	(0.92 - 2.58)	2.44	(1.71 - 3.47)
Southwest	3.79	(2.46 - 5.79)	7.69	(5.35 - 10.94)	1.22	(0.70 - 2.14)	2.05	(1.38 - 3.04)

Impact & Consequences: (according to past and current priority setting processes)

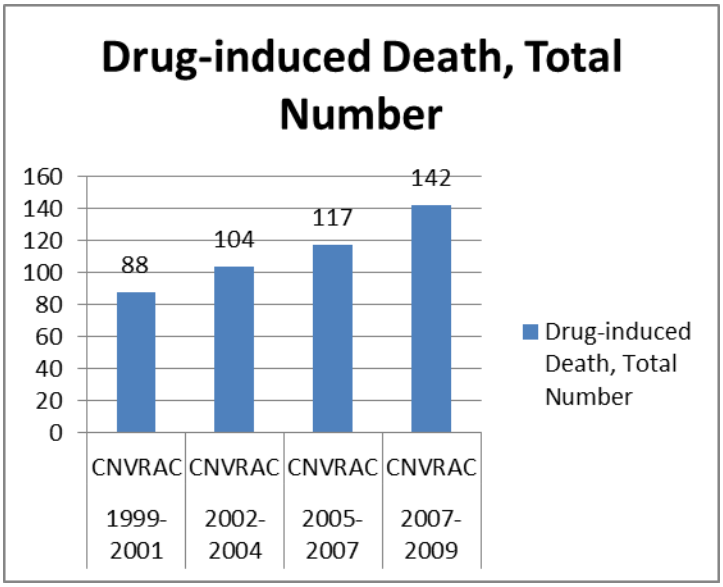
- Heroin is a highly addictive drug and its abuse has repercussions that extend far beyond the individual user. The medical and social consequences of drug abuse – HIV/AIDS, tuberculosis, fetal effects, crime, violence, and disruptions in family, workplace, and educational environments — have a devastating impact on society and cost billions of dollars each year. In the United States, the cost of heroin addiction including the cost to treat, economic and social costs like loss of productivity has been estimated to be $26.4 billion.

- Chronic heroin use can lead to serious medical consequences such as fatal overdose, scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses and other soft-tissue infections, and liver or kidney disease. Poor health conditions and depressed respiration from heroin use can cause lung complications, including various types of pneumonia and tuberculosis.

- Addiction is the most detrimental long-term effect of heroin use because it is a chronic, relapsing disease characterized by compulsive drug seeking and use.

- Long-term effects of heroin use also can include arthritis and other rheumatologic problems and infection of blood borne pathogens such as HIV/AIDS and hepatitis B and C (which are contracted by sharing and reusing syringes and other injection paraphernalia). It is estimated that injection drug use has been a factor in one third of all HIV and more than half of all hepatitis C cases in the United States.

- Heroin use by a pregnant woman can result in a miscarriage or premature delivery. Heroin exposure in utero can increase a newborns' risk of sudden infant death syndrome (SIDS).



Recommendations (from 2010 process)

Increase collection of data and information about the incidence of heroin use is necessary, at the state and local levels, especially among persons aged 18 and older.

CNAW members in some regions believe that heroin use has increased somewhat over the last two years, especially in the 18 to 25 year old population, and to a lesser extent, the high school population, and is an issue that will need to be watched closely in the coming two years.

Prevention Priority 6: Tobacco

Magnitude

The 2010 National Survey of Drug Use and Health (NSDUH) reported a slightly lower prevalence of tobacco product use by all age groups in Connecticut compared to the nation. In addition, data over time from the NSDUH shows that cigarette smoking in Connecticut has been steadily decreasing since 1999. Regionally though, individuals in the Northwestern part of the state where the CNVRAC service area is located, shows the highest estimates of tobacco product users in both the 12-17 age group and the 18-25 age group. The 2010 Connecticut Adult Tobacco Survey found that 16.6% of the state's population age 18 or older was currently using tobacco (more than 444,000 people), including 75% who smoke daily and 44% of whom smoke a pack of cigarettes or more per day. The highest rates of smoking were found among men (20.8%), adults aged 18-24 (29.1%), and Hispanics adults (25.7%).

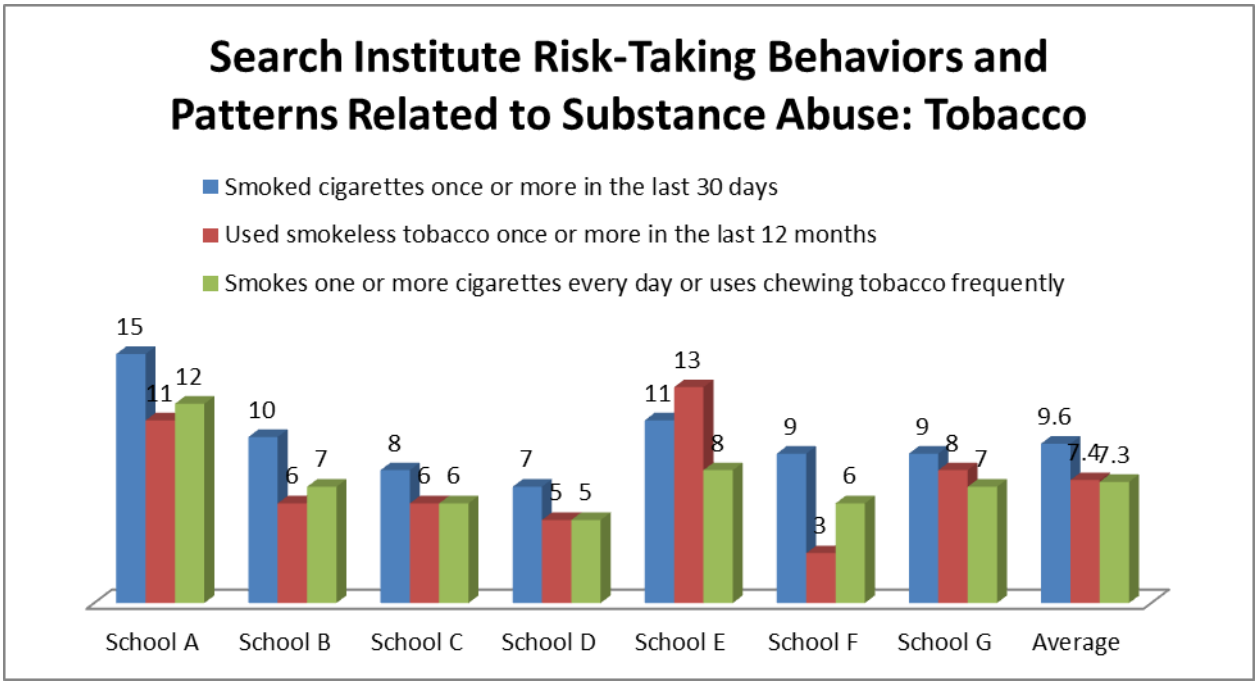
Tobacco Product Use in the Past Month, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

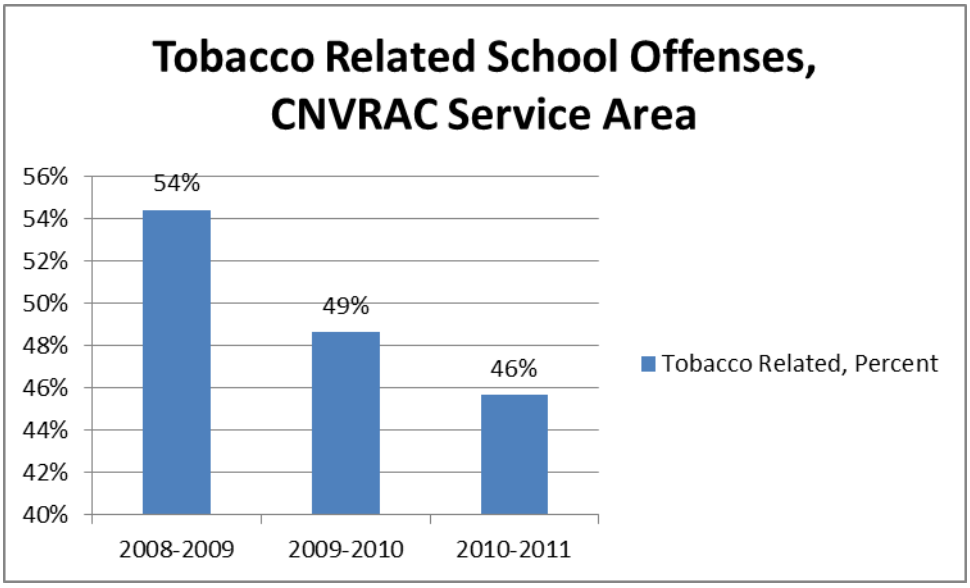
State/Substate Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	11.32	(10.99 - 11.66)	41.43	(40.86 - 42.00)	27.70	(27.20 - 28.21)	29.73	(29.29 - 30.17)
Northeast U.S.	10.99	(10.38 - 11.63)	41.18	(40.02 - 42.36)	25.69	(24.71 - 26.69)	27.92	(27.09 - 28.76)
Connecticut	10.62	(8.95 - 12.54)	41.22	(37.91 - 44.62)	24.33	(21.79 - 27.05)	26.67	(24.36 - 29.11)
Eastern	10.28	(7.53 - 13.89)	*	(* - *)	26.53	(22.17 - 31.41)	29.07	(24.88 - 33.65)
North Central	10.50	(8.25 - 13.27)	41.08	(35.69 - 46.69)	24.73	(21.14 - 28.72)	26.94	(23.55 - 30.61)
Northwestern	11.54	(8.72 - 15.11)	44.02	(37.96 - 50.26)	23.73	(19.96 - 27.96)	26.37	(22.79 - 30.29)
South Central	11.32	(8.69 - 14.62)	40.19	(34.93 - 45.68)	25.03	(21.30 - 29.17)	27.15	(23.67 - 30.94)
Southwest	9.34	(6.96 - 12.43)	40.33	(33.82 - 47.19)	21.97	(18.31 - 26.12)	24.33	(20.77 - 28.28)

* Low precision; no estimate reported.

In review of data collected from the CT School Health Survey Report, it appears that smoking among middle and high school students has both steadily declined since 2000, from 25.6% of high school students and 9.8% of middle school students surveyed in 2000 to 14% of high school students and 2.9% of middle school students surveyed in 2011.

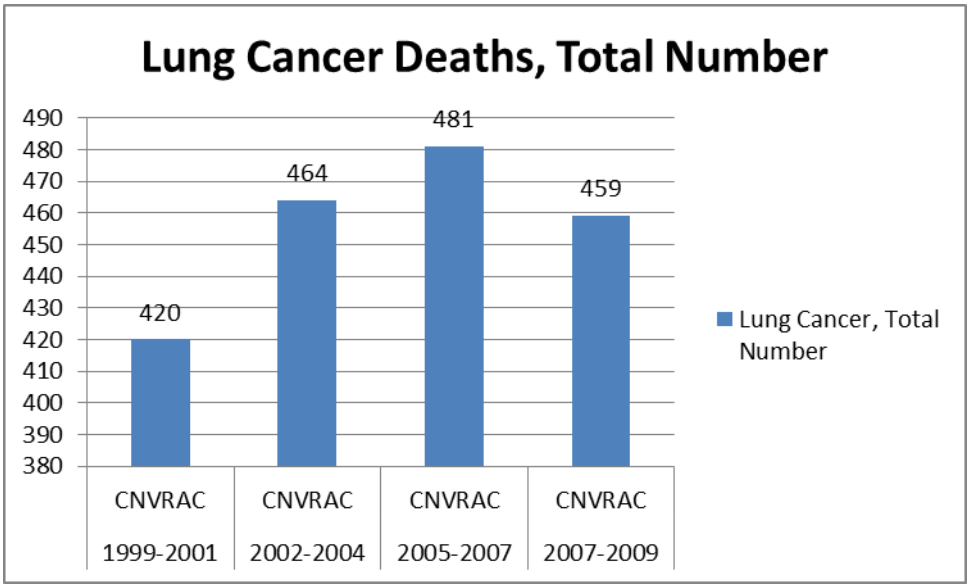
Smoking patterns across CNVRAC service area - youth in grades 6 – 12 surveyed from 2009 - 2012

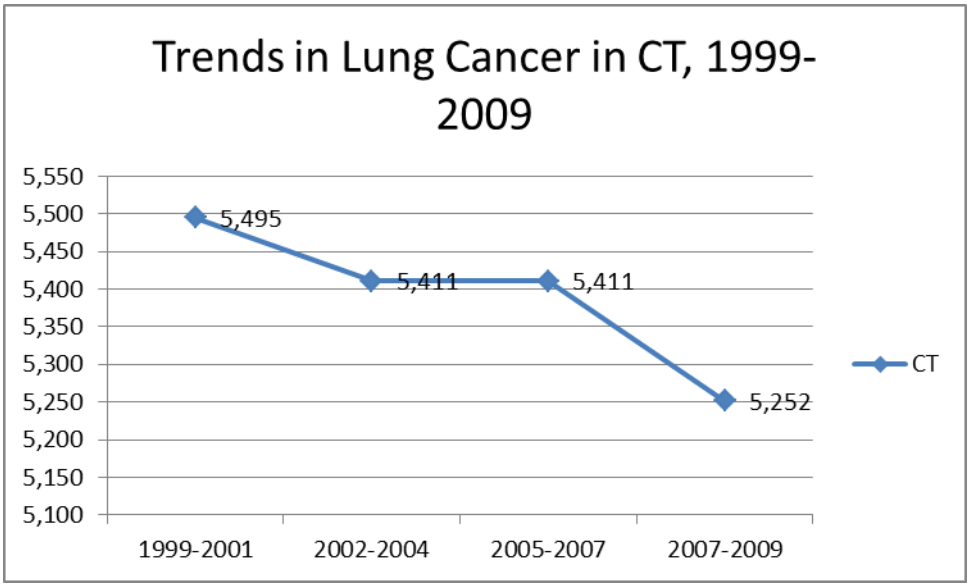




Impact (according to past & present priority setting processes)

- More than 400,000 deaths in the U.S. each year are attributed to cigarette smoking, making it the leading preventable cause of death. In Connecticut, more than 5,200 people annually die from smoking-related diseases.
- Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. Heart disease is the leading cause of death in the US and in Connecticut, and the leading cause of heart disease is smoking.
- Approximately 80% of chronic obstructive pulmonary (COPD) and emphysema deaths are attributable to smoking.
- Smoking is believed to be responsible for 90% of all cancer deaths and 30% of most other cancer deaths in the United Sates.





- Environmental tobacco smoke increases the risk for heart disease and lung cancer among nonsmokers.
- Careless smoking is the leading cause of fatal fires in the U.S.
- According to the American Lung Association (2012) the use of tobacco products currently costs the state of Connecticut $3,575,683,835 due to direct health care expenditures, workplace productivity losses and premature death.
- Put a different way, the average retail price of a pack of cigarettes in Connecticut is $7.45. But the real price of a pack of cigarettes to society and to the state's economy is $22.94 per pack (ALA, 2012).

From CT Tobacco Use Prevention & Control Program (2012):

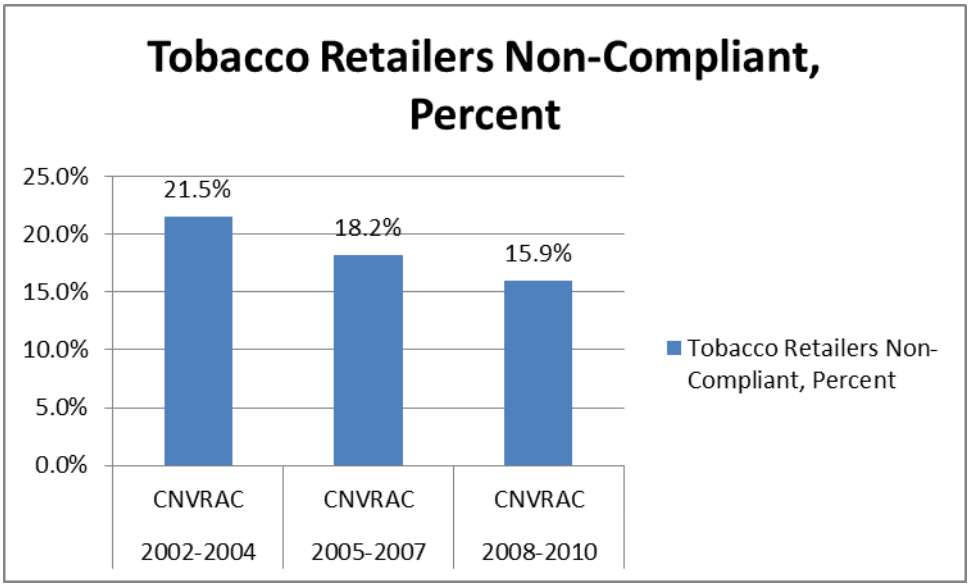
IN CONNECTICUT

- There are 612,301 (17.1%) adult tobacco users.
- Almost 80,000 middle school and high school students have tried cigarette smoking, and each year 4,300 kids become daily smokers.
- Every year approximately 4,700 people die as a result of their smoking.
- 186,000 kids are exposed to secondhand smoke in their home.

Recommendations

For every dollar Connecticut spends on providing tobacco cessation treatments, it has an average potential return on investment of $1.37 (ALA, 2012). Availability and public awareness of tobacco use cessation programs in CT has increased since the last priority setting process. Funding to support these programs and their availability to current smokers and high risk populations should continue.

Environmental prevention strategies are the most effective and such efforts as point-of-sale ID checks and compliance inspections should be continued to prevent persons under 18 from purchasing tobacco products. According to SAMHSA the FFY2011 Synar Report recorded the lowest retailer violation rate in the history of the Synar program.


Tobacco Retailers Non-Compliant, Percent
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
21.5%
18.2%
15.9%
CNVRAC 2002-2004
CNVRAC 2005-2007
CNVRAC 2008-2010
Tobacco Retailers Non-Compliant, Percent

Prevention Priority 7: Cocaine

Magnitude

NIDA Notes 2009 Report

The proportion of people in the United States who have used cocaine at some time during their lives is higher—by a factor of four—than in 16 other nations surveyed by the World Health Organization (2009).

NIDA scientists suggest that the high U.S. rates are, in part, artifacts of drug epidemics of the 1970s and 1980s, and they note that U.S. drug use rates are now lower. Between 2001 and 2006, WHO researchers asked 54,069 people about their lifetime exposure to cocaine, cannabis, tobacco, and alcohol. The survey is the first to publish directly comparable self-report data from a large number of countries. The analysis includes data from the first 17 countries participating in the WHO World Mental Health Survey Initiative.

Sixteen percent of U.S. respondents said they had ever used cocaine, as compared with about 4 percent of people surveyed in Colombia, Mexico, New Zealand, and Spain. Rates of lifetime cocaine use dipped much lower in the other nations. For cannabis, New Zealand is the only nation to nearly match the U.S. rate of 42.4 percent. Lifetime tobacco use in the United States is 73.6 percent, with Lebanon next, at 67.4 percent.

Rates of lifetime alcohol use, which exceed 90 percent in 8 of the 17 countries surveyed, are far higher than for the three other substances. Ukraine reports the highest rate (97 percent), and the United States ranks sixth with 91.6 percent. Alcohol use is much more common in the Americas, Europe, Japan, and New Zealand than in Africa, China, and the Middle East.

Lifetime Versus Current Use

The WHO survey did not query past-year or current substance use as do most U.S. nationwide surveys. "A survey of lifetime use does not provide the entire picture because it does not reflect current use or trends over time," notes NIDA Director Dr. Nora D. Volkow. "For example, although lifetime use of tobacco was reported by this study to be roughly 74 percent in the United States, current use has been documented at approximately 30 percent."

Dr. Wilson Compton of NIDA's Division of Epidemiology, Services and Prevention Research agrees that the study "does not take into account improvements in current drug use." But the fundamental finding that drug-use rates are generally higher in the United States than in most other countries has been confirmed, he says, by indirect indicators, such as drug-treatment admissions, hospitalization rates, and criminal justice data published by the United Nations Office on Drugs and Crime.

Use of Addictive Substances Around the World: Among 17 nations surveyed by the World Health Organization, the United States ranks first in lifetime use of three substances - cocaine, cannabis, and tobacco - and is in sixth place for alcohol use. The five highest rates of use in each drug category appear in bold. Rates are reported as percentages.

Country	Cocaine	Cannabis	Tobacco	Alcohol
Colombia	4.0	10.8	48.1	94.3
Mexico	4.0	7.8	60.2	85.9
US	16.2	42.4	73.6	91.6
Belgium	1.5	10.4	49.0	91.1
France	1.5	19.0	48.3	91.3
Germany	1.9	17.5	51.9	95.3
Italy	1.0	6.6	48.0	73.5
Netherlands	1.9	19.8	58.0	93.3
Spain	4.1	15.9	53.1	86.4
Ukraine	0.1	6.4	60.6	97.0
Israel	0.9	11.5	47.9	58.3
Lebanon	0.7	4.6	67.4	53.3
Nigeria	0.1	2.7	16.8	57.4
South Africa	0.7	8.4	31.9	40.6
Japan	0.3	1.5	48.6	89.1
People's Republic of China	0.0	0.3	53.1	65.4
New Zealand	4.3	41.9	51.3	94.8

Dr. Compton suggests that one reason for the high U.S. lifetime rates might be that drug-use epidemics in the United States, including a major cocaine epidemic in the 1970s and another in the late 1980s, preceded those of other nations by a decade or more. "For people of middle age, lifetime exposure [to cocaine] in the United States would be greater than for the rest of the world," he says. "The differences are less pronounced when you look at young people."

Other Findings

The WHO researchers report substance-use patterns that transcend national boundaries. Among them:

- The period of high risk for initiating use of the surveyed substances—previously late adolescence through the early 20s—now extends into the late 20s.
- Men are more likely than women to use cocaine, cannabis, tobacco, and alcohol, but this gender gap appears to be narrowing in the younger cohorts. Dr. Compton says one factor in gender-based patterns is opportunity to use. "In the past, adolescent boys had more exposure than girls," he says. "Given equal opportunity to use drugs, the rates are similar."
- The higher a person's income, the more likely he or she is to use each of the four substances surveyed.

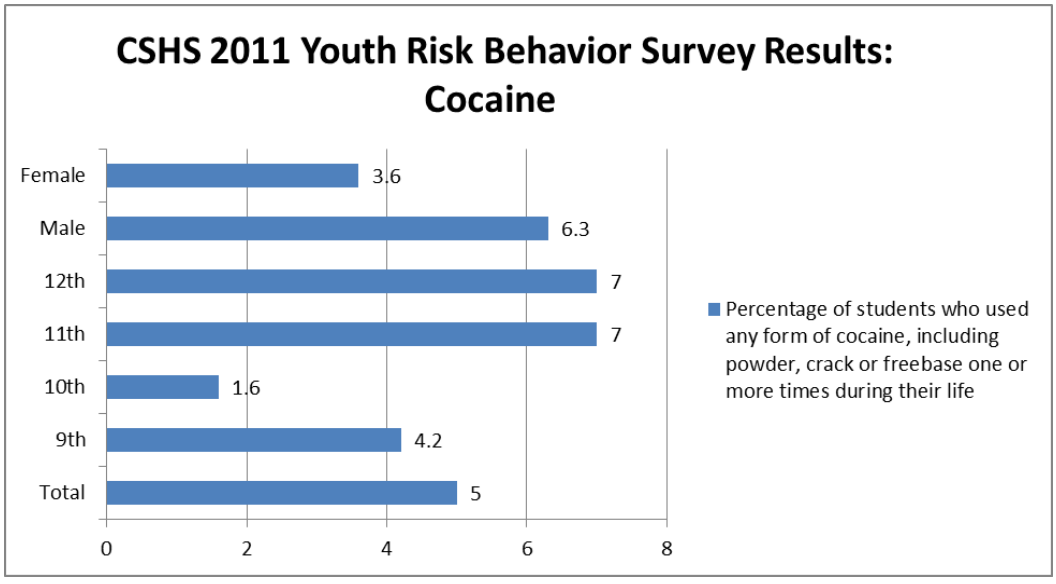
Among Connecticut residents, 18-25 year olds remain the greatest consumers of cocaine at 9% of all users. Also, data from the 2006 Core Survey of Connecticut college students found that the prevalence of current cocaine use increased from 2.7% in 2001 to 3% in 2006.

Cocaine Use in the Past Year, by Age Group and Sub-state Region: Percentages, Annual Averages Based on 2008, 2009, and 2010 NSDUHs

State/Sub-state Region	AGE GROUP							
	12-17		18-25		26 or Older		18 or Older	
	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval	Estimate	95% Confidence Interval
Total U.S.	1.07	(0.97 - 1.18)	5.19	(4.95 - 5.44)	1.48	(1.38 - 1.60)	2.03	(1.93 - 2.14)
Northeast U.S.	1.05	(0.90 - 1.21)	6.32	(5.83 - 6.85)	1.78	(1.55 - 2.06)	2.44	(2.21 - 2.68)
Connecticut	1.18	(0.85 - 1.62)	5.25	(4.01 - 6.84)	1.35	(0.85 - 2.13)	1.89	(1.34 - 2.65)
Eastern	*	(* - *)	4.62	(2.89 - 7.31)	1.29	(0.67 - 2.47)	1.87	(1.15 - 3.04)
North Central	1.12	(0.69 - 1.79)	4.99	(3.38 - 7.29)	1.23	(0.66 - 2.27)	1.73	(1.11 - 2.69)
Northwestern	1.40	(0.83 - 2.36)	5.85	(3.82 - 8.86)	1.46	(0.77 - 2.74)	2.03	(1.26 - 3.26)
South Central	1.17	(0.71 - 1.91)	6.04	(4.19 - 8.65)	1.46	(0.79 - 2.69)	2.10	(1.36 - 3.24)
Southwest	1.10	(0.65 - 1.86)	4.55	(2.86 - 7.18)	1.31	(0.68 - 2.49)	1.72	(1.04 - 2.85)

* Low precision; no estimate reported.

The 2011 YRBSS data report that 4.2% of 9th graders in Connecticut had ever used cocaine compared to 7% of 12th graders in the same year. Connecticut's 10th grade high school students reported the lowest use, at 1.6%. This is higher than CT high school youth reports of lifetime heroin use (4.1% at highest for 11th graders, 1.2% at lowest for 10th



graders), but lower than lifetime use of OTC and prescription drugs: 11.3% OTC use by 12th graders and 11.9% of abusable prescription drugs, again by 12th grade youth.

Impact & Consequences

According to Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS) for 2011 CT treatment admissions 5.5% or 3,418 individuals presented with crack cocaine as their primary substance of abuse. Another 3.4% or 2,133 individuals presented with powder or other forms of cocaine as their primary substance of abuse.

- There are significant physical, mental and social problems associated with cocaine use, abuse and addiction. In 2001, the social cost of cocaine consumption was estimated to be $62.6 billion — the third largest cost for any drug after both tobacco and alcohol.

- Negative physical consequences include: cardiovascular disease, including hypertension, arrhythmia, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction, erosion of dental enamel, rhinitis, perforation of nasal septum, seizures, lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in pregnant women, and infections (HIV, hepatitis B or C, tetanus) from sharing needles.

- Psychological consequences include: anxiety, depression, suicidal feelings and behaviors, insomnia, emotional instability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder, depression, or mania can be triggered or exacerbated by cocaine use or withdrawal.

- Cocaine use is associated with damaged family and social relationships, child abuse or neglect, lost jobs, accidents, prostitution, spread of infections, criminal behaviors, violence and homicide.

- In 2001, data from the Connecticut Office of the Chief Medical Examiner indicated that cocaine was a factor 16.6% of all deaths statewide involving drugs.

- Data from Connecticut's substance abuse treatment system show that there were 5,754 primary cocaine abuse treatment admissions in 2003, representing 12.6% of all treatment admissions statewide. The number of cocaine-related treatment admissions remained higher than the number of treatment admissions for any other illicit drug except heroin.

Recommendations

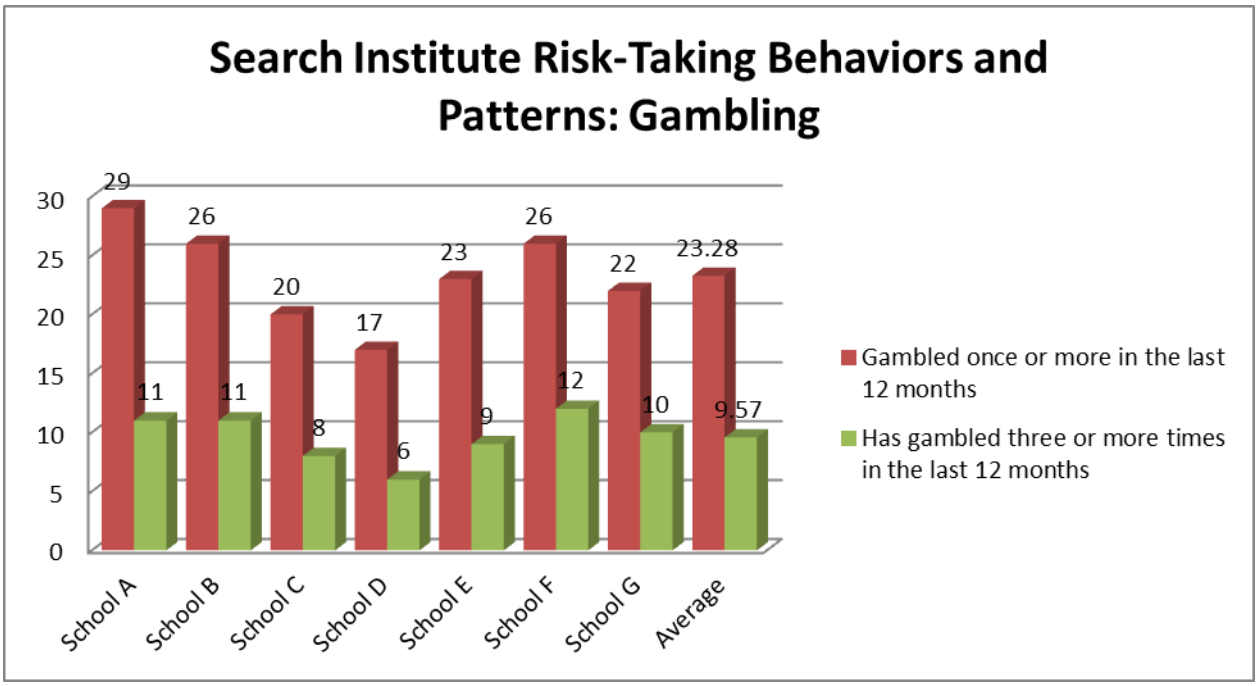
Ongoing monitoring of school and treatment data; maintain efforts in the area of education, law enforcement, and treatment capacity for dealing with cocaine.

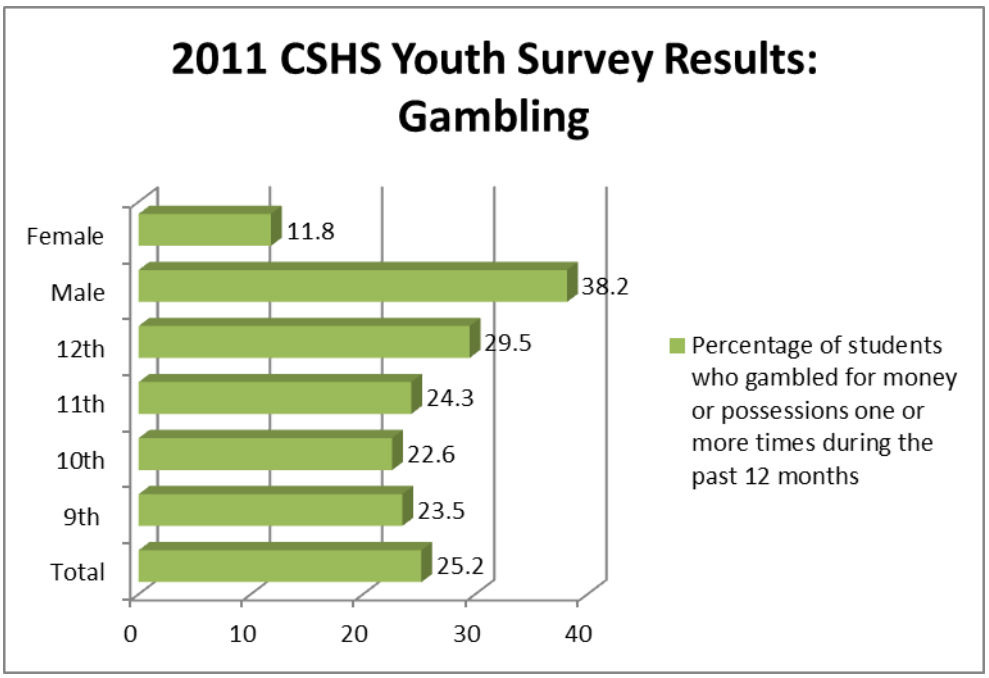
Prevention Priority 8: Problem Gambling

Magnitude

According to DMHAS Problem Gambling Services (2009), the vast majority of people in CT who choose to gamble do so with little or no adverse consequences. However, gambling impacts the brain in the same manner as addictive drugs and during the past two decades, gambling disorders have increased among adults. Prevalence of problem gambling appears to vary according to population and increased access to gambling opportunities appear to be correlated with increased prevalence of gambling problems. Gambling disorders are significantly more prevalent among young people than among the general population, and are significantly more prevalent among males than females.

Local-level data for gambling activity among CNVRAC youth indicate that 17-29% of those surveyed reported having gambled once or more in the past 12 months, an average of 23.3% of the CNVRAC sample, compared to 25.2% of youth reported in the 2011 CSHS survey sample.





Other sources of current state and local-level gambling data appear to be limited, such as data regarding indivudals presenting for treatment, and demographics of this who seek help for a gambling problem.

Impact

Gambling problems hurt families in many ways by creating financial problems; emotional problems and isolation; physical and mental health issues (such as abuse of other substances like alcohol or drugs) due to additional stress, both for the gambler, other family members, and children; physical and emotional abuse; anxiety & depression; and potentially increased suicide risk for the person who gambles excessively.

Recommendations

- While gambling behavior is fairly prevalent in high schools, it is often not seen as “problem gambling”. CNVRAC will continue to deliver “gambling informed” prevention services to the area, and to particular at-risk populations such as the elderly.

- More research is needed to measure changes in prevalence and to better understand the impacts of problem gambling on CT’s communities.

- Improve outreach to those already struggling financially who may be at a higher risk for problem gambling and to a broader range of cultural groups.

Appendix 1: Data Sources

Census Data

Definitions

Age: The age of the person in complete years at the time of census interview.

Sex: Individuals mark either “male” or “female” to indicate their biological sex.

Race: The racial classifications used by the Census Bureau adhere to standards issued by the federal Office of Management and Budget. OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race and that respondents should be offered the option of selecting one or more races. If an individual did not provide a race response, the race or races of the householder or other household members were imputed using specific rules of precedence of household relationship.

Hispanic or Latino Origin: Hispanics or Latinos who identify with the terms “Hispanic,” “Latino,” or “Spanish” are those who classify themselves in one of the specific Hispanic, Latino, or Spanish categories listed on the questionnaire (“Mexican,” “Puerto Rican,” or “Cuban”) as well as those who indicate that they are “another Hispanic, Latino, or Spanish origin.” People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are “another Hispanic, Latino, or Spanish origin” are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or the Dominican Republic. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Educational Attainment: Respondents are classified according to the highest degree or the highest level of school completed. Educational attainment data are needed for use in assessing the socioeconomic condition of the U.S. population. Government agencies also require these data for funding allocations and program planning and implementation. These data are needed to determine the extent of illiteracy rates of citizens in language minorities in order to meet statutory requirements under the Voting Rights Act. Based on data about educational attainment, school districts are allocated funds to provide classes in basic skills to adults who have not completed high school.

Median Age: The median age is the age that divides the population into two equal-size groups. Half of the population is older than the median age and half is younger. Median age is based on a standard distribution of the population by single years of age and is shown to the nearest tenth of a year.

Poverty Status: To determine a person's poverty status, one compares the person’s total family income in the last 12 months with the poverty threshold appropriate for that person's family size and composition. If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered “below the poverty level,” together with every member of his or her family. If a person is not living with anyone related by birth, marriage, or adoption, then the person's own income is compared with his or her poverty threshold. The total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold.

Source
2008-2010 American Community Survey Connecticut Estimates, prepared by the U.S. Census Bureau, 2011.

Arrests for Driving Under the Influence

Definition
Arrests recorded for driving or operating any motor vehicle or common carrier while drunk or under the influence of liquor or narcotics.

Source
Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths
Driving under the influence (DUI) is a direct consequence of alcohol or drug misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations
Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Liquor Law Violations

Definition
Arrests recorded for possession of alcohol by minor, sale or provision of alcohol to minors, or fake/false identification. This does not include public drunkenness, driving under the influence or administrative actions taken by the Department of Consumer Protection Liquor Control Commission against liquor permittees.

Source
Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths
Liquor law violations are a direct consequence of alcohol misuse. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations
Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Arrests for Drug Law Violations

Definition
Arrests related to narcotic drugs, such as unlawful possession, sale, use, growing and manufacturing of narcotic drugs.

Source
Connecticut Department of Emergency Services and Public Protection, Crimes Analysis Unit, Middletown CT

Strengths
Narcotic drug law violations are a direct consequence of drug use. These data are derived from Uniform Crime Reports, which are set up with numerous internal crosschecks to achieve reporting accuracy.

Limitations
Because a person arrested in one town may live in another, this indicator may not reflect actual DUI arrests for the residents of a given town. Arrest data from Connecticut state universities, casinos, and other municipal and state law enforcement agencies who participate in the Connecticut UCR System were included in the city and town totals until 2007. As a result, the numbers of arrests before 2007 may be higher than those published in the official UCR.

Alcohol-Involved Motor Vehicle Accidents

Definition
Motor vehicle accidents for which the driver had consumed alcohol (Blood Alcohol Concentration >0.00)

Source
Connecticut Department of Transportation Traffic Accident Viewing System, Newington CT

Strengths
Alcohol motor vehicle involved accidents are a direct consequence of alcohol misuse. The information is routinely collected as part of the Department of Transportation's Traffic Accident Viewing System.

Limitations:
The rates may underestimate the actual occurrence due to underreporting. A person involved in an accident in particular town may not reside in that town.

Fatal Motor Vehicle Accidents while Under the Influence of Alcohol or Drugs

Definition
Motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00)or was reported to be under the influence of drugs.

Source
National Highway Traffic Safety Administration (NHTSA), Fatal Accident Reporting System (FARS)

Strengths
Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations
Alcohol Test Result statistical data obtained from this database should be interpreted with caution. Alcohol Test Results included in this database are actual state-reported data. Estimates obtained by use of this query system may differ from NHTSA's published reports. NHTSA's published estimates are based on data from the Fatality Analysis Reporting System (FARS). Unfortunately, known BAC test results are not available for all drivers and non-occupants involved in fatal crashes. “Property Damage Only” accidents, which occurred on locally maintained roadways from 01/01/2007 to the present are included in the DOT accident file; prior to that date, they were not included in the file. The rates may underestimate the actual occurrence due to underreporting, and also a person involved in an accident in particular town may not reside in that town.

Motor Vehicle Accident Fatalities while Under the Influence of Alcohol or Drugs

Definition
Total fatalities in motor vehicle accidents in which at least one person died for which at least one driver, pedestrian, or cyclist had consumed alcohol (Blood Alcohol Concentration >0.00) or was reported to be under the influence of drugs.

Source
National Highway Traffic Safety Administration (NHTSA), Fatality Analysis Reporting System (FARS)

Strengths
Alcohol/drug involved motor vehicle involved accidents are a direct consequence of alcohol/drug misuse. Data on fatal traffic crashes have been systematically collected by NHTSA for many years in Connecticut making geographic comparisons possible.

Limitations
This indicator may be unstable for less populated areas that have low numbers of annual fatal crashes. While considerable effort has been made to obtain the BAC values for all drivers involved in fatal crashes, these data are not complete. Therefore, NHTSA estimates driver BAC for cases missing data.

Lung Cancer Deaths

Definition
Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes C34 as the underlying cause of death.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
Eighty to 90% of all lung cancer is attributable to cigarette smoking. Data on lung cancer deaths are readily available for many years.

Limitations
Death from lung cancer reflects long-term, chronic cigarette smoking, and lung cancer has a long latency period. Therefore, it may be many years before changes in smoking affect population mortality. The stability of this indicator is

directly related to the size of the population in which these deaths occur and may be unstable for less populated states or when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death.

Alcohol-Attributable Chronic Liver Disease and Cirrhosis Deaths

Definition
Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes K70, K73, or K74 as the underlying cause of death.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
Long term, heavy alcohol consumption is the leading cause of chronic liver disease, in particular cirrhosis, one of the 12 leading causes of death. According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 40% of deaths from cirrhosis in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations
This indicator is only based on deaths; cases of cirrhosis morbidity are not reflected in this indicator. Alcohol-related cirrhosis may have a long latency; there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups.

Alcohol-Attributable Suicides

Definition
Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X60-X84, Y87.0 as the underlying cause of death.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 23% of suicides in Connecticut were attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations:
The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as suicide, are best used at the state or regional levels.

Alcohol-Attributable Homicides

Definition
Deaths recorded with International Statistical Classification of Diseases (ICD)-10 codes X85-Y09 and Y87.1 as the underlying cause of death. Homicide includes injuries inflicted by others that result in death.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
According to the Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) website, from 2001 to 2005, 47% of homicides in Connecticut attributable to alcohol use. This indicator is available over several years at the state and town level.

Limitations
The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes. Indicators based on rare events, such as homicide, are best used at the state or regional levels.

Alcohol-Induced Death

Definition
Alcohol-induced deaths include alcohol-induced pseudo-Cushing's syndrome; mental and behavioral disorders due to alcohol use; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol-induced acute pancreatitis; alcohol-induced chronic pancreatitis; finding of alcohol in blood; accidental poisoning by and exposure to alcohol; intentional self-poisoning by and exposure to alcohol; and poisoning by and exposure to alcohol, undetermined intent. Alcohol-induced causes exclude accidents, homicides, and other causes indirectly related to alcohol use, as well as newborn deaths associated with maternal alcohol use.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
These deaths are a direct consequence of alcohol misuse.

Limitations
The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Drug-Induced Death

Definition
Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs (e.g., heroin or cocaine), as well as legal prescription drugs and over-the-counter drugs; alcohol is not included. The majority of deaths are unintentional drug poisoning deaths, with suicidal drug poisoning and drug poisoning of undetermined intent comprising the majority of the remainder. Adverse effects from drugs taken as directed and infections resulting from drug use are not included. In 2007, drug-induced deaths were more common than alcohol-induced or firearm-related deaths in the United States.

Source
Connecticut Department of Public Health Mortality Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388138

Strengths
These deaths are a direct consequence of drug misuse.

Limitations
The stability of this indicator is directly related to the size of the population in which these deaths occur. This indicator may be unstable for areas or subgroups that have small population sizes.

Alcohol and Other Drug Related School Suspension or Expulsion

Definition
A sanction determined the school administration due to violation of a publicized policy; or serious disruption of the educational process; or endangerment to persons or property.

Source
Connecticut State Department of Education disciplinary offense records

Strengths
Students who use alcohol, tobacco or other drugs at an early age and use substances frequently are more likely than other students to continue to face suspension or expulsion. These data are based on uniform definitions applied to all schools in the state and, therefore, have comparative values.

Limitations
The definition for counting drug or alcohol disciplinary offense is uniformly defined statewide. However, the specific data collection requirements have changed in recent years. Therefore, these data are not necessarily comparable across years. The data should be used with discretion.

Overall school attendance in past year

Definition
Overall school attendance is the number of students attending public school each day of the school year, divided by the number of days school was in session during the school year.

Source
Connecticut State Department of Education. School attendance records

Strengths
Researchers have found that truancy itself seems to contribute to or at least correlate with a diverse array of problems among young people. Studies have established lack of commitment to school and truancy as risk factors for substance abuse, teen pregnancy, delinquent behavior, and school dropout.

Limitations
This indicator is an indirect measure of substance abuse and its consequences.

Tobacco Retailer Violation

Definition
Tobacco retailers who sold tobacco to minors working undercover for the CT DMHAS Tobacco Prevention and Enforcement Program.

Data Source
Connecticut Department of Mental Health and Addiction Services Tobacco Prevention and Enforcement Program

Strengths
Tobacco use by minors is a consequence of access to tobacco products. The Synar Amendment requires states and U.S. jurisdictions to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons under 18. As a result, over the last 14 years, data reported by states and the District of Columbia has indicated a clear downward trend towards reducing tobacco sales to minors. Data on retailer violations have been systematically collected by DMHAS for many years.

Limitations
This indicator may be unstable for areas or subgroups that have small population sizes, which are not routinely subject to inspections by DMHAS.